STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
45 FREMONT STREET, 21st FLOOR
SAN FRANCISCO, CALIFORNIA 94105

RH-399

Fair Claims Settlement Practices Regulations
Response to Comments

Comments RE: RH 399, generally

Comment No.: **12**
Section: **RH 399, generally**
Commentator: Gilbert E. Stein and Peggy Sugarman, California Applicants' Attorneys Association ("CAAA")
Date of Comment: May 7 and 8, 2002
Type of Comment: Written and Oral

Summary of Comment: CAAA urges the Department to include workers' compensation insurer claim practices within the purview of these regulations. During public discussions relating to RH 399, the proposed amendments included workers compensation insurer claim conduct but the proposed amendments that were the subject of public hearings no longer had this inclusion.

Response to Comment: This comment is outside the scope of the proposed rulemaking. Pursuant to Government Code Section 11347, the commentator may, if he/she so chooses, petition the Department requesting the adoption, amendment or repeal of a regulation.

Comment No.: **Oral - See Transcript in Rulemaking File**
Section: **RH 399, generally**
Commentator: Robert Scott
Date of Comment: May 9, 2002
Type of Comment: Oral

Summary of Comment: The regulations should specify that individual claimants and not just the Commissioner may enforce the minimum claims handling standards set forth in the regulations.

Response to Comment: The Commissioner has considered this comment and rejects it. The Commissioner lacks the authority to promulgate the suggested language.

Comments RE: Section 2695.1(b)

Comment No.: **18**
Section: **2695.1(b)**
Commentator: Samuel Sorich, National Association of Independent Insurers
Date of Comment: May 8, 2002
Type of Comment: Oral and Written

Summary of Comment: Insurance Code Section 790.06 establishes a procedure allowing the Commissioner to take action against an insurer for engaging in conduct not specifically defined in Insurance Code Section 790.03(h). The proposed amendments to this section are inconsistent with Insurance Code Sections 790.06 and 790.03 as they would allow the Commissioner to take an enforcement action for an undefined unfair practice based on Section 790.03 itself without any obligation to follow the procedure in Section 790.06. This essential link between Sections 790.03 and 790.06 must be preserved in order to maintain compliance with the Insurance Code's enforcement scheme.

Response to Comment: The Commissioner has considered the comment, accepts it in part and rejects it in part. The intent of this section is to make clear that the regulations do not set forth the exclusive definition of all unfair claims settlement practices. Other methods, acts or practices not specifically referred to in the regulations may also be unfair claims practices. Neither the current nor the proposed language satisfies this goal. Therefore, proposed Section 2695.1(b) is clarified to read as follows:

> (b) These regulations are not meant to provide the exclusive definition of all unfair claims settlement practices~~.~~ **. O**~~o~~ther methods, act(s), or practices not specifically delineated in this set of regulations may also be **unfair claims settlement practices** ~~a violation of California Insurance Code Section 790.03(h) pursuant to the provisions of California Insurance Code Section~~ **or** ~~790.06~~. These regulations are applicable to the handling or settlement of **all** claims ~~brought under all classes of insurance~~ **subject to Article 6.5 of Division 1, Part 2, Chapter 1 of the California Insurance Code, commencing with Section 790,** except as specifically provided below:

Comment No.: **11**
Section: **2695.1(b)**
Commentator: Jeffrey J. Fuller, Association of California Insurance Companies
Date of Comment: May 7 and 8, 2002
Type of Comment: Written and Oral

Summary of Comment: The proposed amendment is, in effect, a disclaimer by the Department that there may be unfair claims practices that it currently does not know about. The amended language is added so that the Department can retroactively apply unfair claim practices criteria to activities that were not previously deemed by the Department to be a violation. This section is unnecessary and disingenuous.

Response to Comment: The Commissioner has considered the comment, accepts it in part and rejects it in part. The language of Insurance Code Section 790.06 is sufficiently broad that the Commissioner is not required to list in these regulations every method, act or practice that may constitute an unfair claims practice. The intent of this section is to make clear that the regulations do not set forth the exclusive definition of all unfair claims settlement practices.

Other methods, acts or practices not specifically referred to in the regulations may also be unfair claims practices. Neither the current nor the proposed language satisfies this goal. Therefore, proposed Section 2695.1(b) is clarified to read as follows:

> (b) These regulations are not meant to provide the exclusive definition of all unfair claims settlement practices~~.~~ **. O**~~o~~ther methods, act(s), or practices not specifically delineated in this set of regulations may also be **unfair claims settlement practices** ~~a violation of California Insurance Code Section 790.03(h) pursuant to the provisions of California Insurance Code Section **or** 790.06~~. These regulations are applicable to the handling or settlement of **all** claims ~~brought under all classes of insurance~~ **subject to Article 6.5 of Division 1, Part 2, Chapter 1 of the California Insurance Code, commencing with Section 790,** except as specifically provided below:

Comment No.: **7**
Section: **2695.1(b)**
Commentator: Dean Hansell, LeBoeuf, Lamb, Greene & MacRae, on behalf of Underwriters at Lloyd's, London
Date of Comment: May 6 and 9, 2002
Type of Comment: Written and Oral

Summary of Comment: While the claims regulations were drafted primarily to protect personal lines, their broad language may be interpreted to apply also to large commercial claims from large corporations. Large companies that purchase commercial lines of insurance are sophisticated businesses whose insurance matters are frequently handled by large brokers, experienced counsel and risk managers. Insurers that write large commercial policies with only remote ties to California may have to comply with the claims regulations if even one additional insured (such as a bank) is a California entity, even if the claim, the insured and the carrier are outside California. Section 2695.1(b) should be amended to add a subsection (5). This section would clarify that the regulations do not apply to large commercial policies where the annual premium exceeds $100,000, and that such exception does not apply to a third party claim asserted pursuant to such a policy.

Response to Comment: The Commissioner has considered the comment and rejects. In a large commercial claim involving multiple parties, the main insurer responsible for administering the claim should be aware of and able to adhere to relevant laws (California or otherwise) relating to the claim. This comment is also beyond the scope of the rulemaking.

Comments RE: Section 2695.1(b)(1)

Comment No.: **4**
Section: **2695.1(b)(1)**
Commentator: John Metz
Date of Comment: April 24 and May 8, 2002
Type of Comment: Written and Oral

Summary of Comment: No statute exempts workers' compensation from Insurance Code Section 790.03. Workers' compensation claims should only be exempted from these regulations in those instances where the statutes relating to workers' compensation insurance conflict with these regulations.

Response to Comment: The Commissioner has considered the comment and rejects it. This comment is rejected as it is outside the scope of the proposed rulemaking.

Comments RE: Section 2695.1(b)(2)

Comment No.: **4**
Section: **2695.1(b)(2)**
Commentator: John Metz
Date of Comment: April 24 and May 8, 2002
Type of Comment: Written and Oral

Summary of Comment: Professional liability insurance claims should only be exempted from these regulations in those instances where the statutes relating to professional liability insurance conflict with these regulations.

Response to Comment: The Commissioner has considered the comment and rejects it. This comment is rejected as it is outside the scope of the proposed rulemaking.

Comments RE: Section 2695.1(c)

Comment No.: **38**
Section: **2695.1(c)**
Commentator: Bill Gausewitz, American Insurance Association
Date of Comment: May 9, 2002
Type of Comment: Written

Summary of Comment: This proposed section deletes the current partial exemption from the regulations for claims under surety bonds. It treats claims under surety bonds identically to those under indemnity policies and fails to recognize the unique tripartite relationship (between the surety, principal and beneficiary) that exists under surety bonds.

Response to Comment: The Commissioner has considered and rejects this comment. Even though a unique tripartite relationship exists between the surety insurer, principal and beneficiary, the surety claims handling process is generally no more complicated than many first or third party claims (which claims are subject to the regulations.) As such, certain minimum standards set forth under the regulations should apply to surety claims. For example, section 2695.7 does not impede the surety's ability to conduct its business efficiently and fairly and in accordance with Insurance Code Section 790.03(h).

Comment No.: **15**
Section: **2695.1(c)**
Commentator: Marilyn Klinger, Sedgwick, Detert, Moran & Arnold on behalf of The Surety Association of America
Date of Comment: May 8, 2002
Type of Comment: Written and Oral

Summary of Comment: The effect of the proposed amendment is to delete the current partial exemption from the regulations for claims under surety bonds. The amended language treats claims under surety bonds identically to those under indemnity policies and fails to recognize the unique tripartite relationship (between the surety, principal and beneficiary) that exists under surety bonds.

Response to Comment: The Commissioner has considered and rejects this comment. Even though a unique tripartite relationship exists between the surety insurer, principal and beneficiary, the surety claims handling process is generally no more complicated than many first or third party claims (which claims are subject to the regulations.) As such, certain minimum standards set forth under the regulations should apply to surety claims. For example, section 2695.7 does not impede the surety's ability to conduct its business efficiently and fairly and in accordance with Insurance Code Section 790.03(h).

Comment No. : **16**
Section: **2695.1(c)**
Commentator: David C. Veis, Robins, Kaplan, Miller & Ciresi on behalf of Developers Surety and Indemnity Company
Date of Comment: May 8, 2002
Type of Comment: Written

Summary of Comment: There is no necessity for the elimination of this section as there is no rational basis for disregarding the unique distinctions between suretyship and insurance. The application of the proposed regulations to surety claims is inconsistent with existing statutory and case law.

Response to Comment: The Commissioner has considered this comment and rejects it. Although the tripartite relationship that exists in connection with a surety bond is unique, statutory and case law does not preclude the application of these regulations to surety claims. The proposed amendment is necessary because the minimum standards for settling claims are as applicable to surety as to other types of claims. These minimum standards work to protect the claimant regardless of the complexity of the claim.

Comment No.: **29**
Section: **2695.1(c)**
Commentator: Steve McManus, State Farm Insurance Companies
Date of Comment: May 9, 2002
Type of Comment: Written

Summary of Comment: This section should not be repealed because the surety claim process is more complex than that of first or third party claims.

Response to Comment: The Commissioner has considered this comment and rejects it. Although the tripartite relationship that exists in connection with a surety bond is unique, statutory and case law does not preclude the application of these regulations to surety claims. The proposed amendment is necessary because the minimum standards for settling claims are as applicable to surety as to other types of claims. These minimum standards work to protect the claimant regardless of the complexity of the claim.

Comment No.: **Oral - See Transcript in Rulemaking File**
Section: **2695.1(c)**
Commentator: W. Potter
Date of Comment: May 9, 2002
Type of Comment: Oral

Summary of Comment: The regulations relating to surety should not be deleted.

Response to Comments: The proposed amendment repeals Section 2695.1(c) which section excluded certain sections of the regulations from being applicable to surety claims. Minimum standards set forth in the regulations, particularly in Section 2695.7, should apply to the handling of surety claims and the amendment would effect that change.

Comment No.: **Oral - See Transcript in Rulemaking File**
Section: **2695.1(c)**
Commentator: Paul Gladfelty, California Surety Federation
Date of Comment: May 8, 2002
Type of Comment: Oral

Summary of Comment: This section should not be repealed because the surety claim process is oftentimes more complex than that of first or third party claims. Also, the Department should handle the issue of contractors' license bonds separately from these regulations.

Response to Comment: The Commissioner has considered this comment and rejects it. Although the tripartite relationship that exists in connection with a surety bond is unique, statutory and case law does not preclude the application of these regulations to surety claims. The proposed amendment is necessary because the minimum standards for settling claims are as applicable to surety as to other types of claims. These minimum standards work to protect the claimant regardless of the complexity of the claim.

Comment No.: **Oral - See Transcript in Rulemaking File**
Section: **2695.1(c)**
Commentator: Jerry Desmond, Association of California Surety Companies
Date of Comment: May 8, 2002
Type of Comment: Oral

Summary of Comment: The amended regulations should just apply to contractors' license bonds.

Response to Comment: The Commissioner has considered this comment and rejects it. The regulations do not impose excessive restrictions on surety companies regardless of what kind of bond is written or the complexity of the claim. In the case of complex claims, the regulations, as amended, allow more time for the surety or other insurer in the event it cannot determine within forty days of receiving proof of claim whether to accept or deny the claim.

Comments RE: Section 2695.1(d)

Comment No.: **9**

Section: **2695.1(d)**
Commentator: Sean E. McCarthy, Stoel Rives LLP, on behalf of Home Warranty Association of California ("HWAC")
Date of Comment: May 7, 2002
Type of Comment: Written

Summary of Comment: The Fair Claims Settlement Practices Regulations ("FCSPR") do not apply to home protection companies because home protection companies are comprehensively regulated by the Home Protection Act and are not included within the FCSPR's definition of "insurer."

Response to Comment: The Commissioner has considered this comment and rejects it. Insurance Code Sections 12740 through 12764 define and establish regulatory provisions for home protection contracts and home protection companies. Insurance Code Section 12743(d)(7) specifically provides that Insurance Code Section 790 et seq., (The Unfair Practices Act), shall be applicable to home protection contracts and home protection companies. Pursuant to Section 12743(j)(1) and (4), the term "insurer," when used in Section 790 et seq., means home protection company, and the terms "policy" and "insurance" means home protection contract. As both home protection companies and contracts are subject to the Unfair Practices Act, the Insurance Commissioner has clear authority under Section 790.10 to adopt regulations applicable to home protection companies and contracts.

Comment No.: **33**
Section: **2695.1(d)**
Commentator: George Spaeth, Spaeth & McGraw, on behalf of Buyers Home Warranty Company
Date of Comment: May 9, 2002
Type of Comment: Written

Summary of Comment: The substance of Sean McCarthy's letter (see above) is incorporated into these comments by reference. Home protection companies and property and casualty insurers doing business in California have nothing in common other than the fact that they are both regulated by the Commissioner. The Commissioner should recognize and honor these differences by exempting home protection companies from the regulations.

Response to Comment: Insurance Code Section 12743 specifies that the Unfair Practices Act (Sections 790.1 through .10) apply to home protection companies. Under Section 790.10, the Commissioner has clear authority to adopt regulations that are applicable to both insurers and home protection companies. As Insurance Code Section 12743(k) specifies, in the event of any conflict between the Unfair Practices Act and the Home Protection Act (commencing with Insurance Code Section 12740), the Home Protection Act prevails.

Comments RE: Section 2695.1(f)

Comment No.: **17**
Section: **2695.1(f)**
Commentator: Douglas K. deVries, Mart & deVries: Joined by Lea-Ann Tratten, Consumer Attorneys of California
Date of Comment: May 8, 2002

Type of Comment: Written

Summary of Comment: I support this addition to the regulations and believe that it is essential to assuring fairness and adherence to law in the handling of insurance claims. The Department is concerned that insurers have written and would continue to write, absent language such as that proposed, contract provisions in an attempt to circumvent regulations.

Response to Comment: The Commissioner agrees with this comment.

Comment No. : **23**
Section: **2695.1(f)**
Commentator: Carol P. LaPlant, Esq.
Date of Comment: May 9, 2002
Type of Comment: Written

Summary of Comment: Section 2695.1(f) is useful because it explicitly states a fundamental compliance standard.

Response to Comment: The Commissioner agrees with this comment. The proposed amendment clarifies that provisions that are part of an insurance policy must either meet or exceed the minimum claims handling standards set forth in the regulations.

Comment No.: **13**
Section: **2695.1(f)**
Commentator: G. Diane Colborn, Personal Insurance Federation of California
Date of Comment: May 7 and 8, 2002
Type of Comment: Written and Oral

Summary of Comment: The proposed amendment exceeds the scope of authority granted to the commissioner to regulate claims settlement practices. The proposed language purports to mandate what provisions must be contained in all insurance policies. The commissioner has no authority to require modification of insurance policy provisions or to establish new standards for coverage.

Response to Comment: The commissioner has considered the comment and rejects it. The proposed amendment does not mandate what provisions must be contained in insurance policies. Rather, the proposed amendment specifies that provisions that are in a policy, which relate to adjustment of claims, must either be consistent with or more favorable to the insured than the regulations.

Insurance Code Section 790.03(h) enumerates 16 unfair claims practices that an insurer is prohibited from performing. Contrary to PIFC's assertion, the Fair Claims Settlement Practices Regulations do not dictate coverage or mandate policy provisions. These regulations set forth the minimum standards that an insurer must adhere to when processing claims. The commissioner has the authority to prohibit policy provisions that would result in unfair claims practices. The language of some policy provisions is in direct conflict with these regulations and, when applied to a claim, would result in a violation of these regulations and Section 790.03(h). As an example, it is an unfair claims practice to "require" an insured to have his/her

auto repaired in a particular auto body shop. An insurer is prohibited from having a policy provision that places this requirement on the insured.

However, in light of these and other similar comments, the Commissioner has clarified the proposed regulation as follows:

> **(f) ~~Provisions of all policies delivered or issued in this state~~ Policy provisions relating to the investigation, processing and settlement of claims shall be consistent with or more favorable to the insured than the provisions of these regulations.**

Comment No. : **38**
Section: **2695.1(f)**
Commentator: Bill Gausewitz, American Insurance Association
Date of Comment: May 9, 2002
Type of Comment: Written

Summary of Comment: This proposed section purports to regulate the provisions of insurance contracts. The proposal lacks authority and is inconsistent with statutory and case law. For example, the provisions of a standard fire insurance policy are defined by Insurance Code Section 2071. The Commissioner lacks the authority to dictate policy terms under the guise of enforcing the claims practice statutes.

Response to Comment: The Commissioner has considered and rejects this comment. The proposed amendment does not mandate what provisions must be contained in insurance policies. Rather, the proposed amendment specifies that provisions that are in a policy, which relate to adjustment of claims, must either be consistent with or more favorable to the insured than the regulations. In other words, policy terms must comply with the law.

Insurance Code Section 790.03(h) enumerates 16 unfair claims practices that an insurer is prohibited from performing. Contrary to the commentator's assertion, these regulations do not dictate coverage or mandate policy provisions. The regulations set forth the minimum standards that an insurer must adhere to when processing claims. The commissioner has the authority to prohibit policy provisions that would result in unfair claims practices. The language of some policy provisions is in direct conflict with these regulations and, when applied to a claim, would result in a violation of these regulations and Section 790.03(h). As an example, it is an unfair claims practice to "require" an insured to have his/her auto repaired in a particular auto body shop. An insurer is prohibited from having a policy provision that places this requirement on the insured.

However, in light of these and other similar comments, the Commissioner has clarified the proposed regulation as follows:

> **(f) ~~Provisions of all policies delivered or issued in this state~~ Policy provisions relating to the investigation, processing and settlement of claims shall be consistent with or more favorable to the insured than the provisions of these regulations.**

Comment No.: **18**
Section: **2695.1(f)**

Commentator: Samuel Sorich, National Association of Independent Insurers
Date of Comment: May 8, 2002
Type of Comment: Oral and Written

Summary of Comment: The proposed section requires policies to be written so that they conform to the amended regulations. The Legislature, not the Department of Insurance, has the authority to mandate policy provisions.

Response to Comment: The Commissioner has considered and rejects this comment. The proposed amendment does not mandate what provisions must be contained in insurance policies. Rather, the proposed amendment specifies that provisions that are in a policy, which relate to adjustment of claims, must either be consistent with or more favorable to the insured than the regulations. In other words, policy terms must comply with the law.

Insurance Code Section 790.03(h) enumerates 16 unfair claims practices that an insurer is prohibited from performing. Contrary to the commentator's assertion, these regulations do not dictate coverage or mandate policy provisions. The regulations set forth the minimum standards that an insurer must adhere to when processing claims. The commissioner has the authority to prohibit policy provisions that would result in unfair claims practices. The language of some policy provisions is in direct conflict with these regulations and, when applied to a claim, would result in a violation of these regulations and Section 790.03(h). As an example, it is an unfair claims practice to "require" an insured to have his/her auto repaired in a particular auto body shop. An insurer is prohibited from having a policy provision that places this requirement on the insured.

However, in light of these and other similar comments, the Commissioner has clarified the proposed regulation as follows:

> **(f) ~~Provisions of all policies delivered or issued in this state~~ Policy provisions relating to the investigation, processing and settlement of claims shall be consistent with or more favorable to the insured than the provisions of these regulations.**

Comment No.: 30
Section: 2695.1(f)
Commentator: Peter J. Fitzpatrick
Dates of Comment: May 9, 2002
Type of Comment: Written and Oral

Summary of Comment: Although the proposed regulation provides that non-conforming policy language is automatically amended to conform to the minimum requirements of California law, courts are generally reluctant to enforce statutory language because of Insurance Code Section 10291.5(k), which provides that a disability policy that has been approved by the Commissioner is conclusively presumed to comply with Section 10291.5(k). Some recognition of this problem should be made in the proposed regulation.

Response to Comment: The Commissioner has considered this comment and rejects it. This subsection, as further amended (see above), specifies that policy provisions relating to claims are to be consistent with or more favorable to the insured than the provisions of the claims regulations. Insurance Code Section 10291.5(k) specifies that disability policies issued by the

insurer are to be on a form approved by the Commissioner and are subject to any of the conditions contained in the policy. A disability policy form would not be approved if it violated any of the claims handling provisions contained in these regulations.

Comment No.: **15**
Section: **2695.1(f)**
Commentator: Marilyn Klinger, Sedgwick, Detert, Moran & Arnold on behalf of The Surety Association of America
Date of Comment: May 8, 2002
Type of Comment: Written and Oral

Summary of Comment: The expectation that the surety industry could comply with this proposed amendment reflects a misunderstanding of what is possible. First, the vast majority of surety bond forms are dictated by statute so sureties are not in a position to alter provisions contained in the forms. Second, the terms of the bonds that are not dictated by statute are dictated by the obligees/beneficiaries of the bonds not by the sureties. Thus, again, sureties are not in a position to alter the provisions of the bond. Finally, this section is unnecessary, as the laws of the state, including insurance regulations, are automatically incorporated into all contracts (including insurance contracts and surety bonds).

Response to Comment: The Commissioner has considered this comment and agrees. This subsection only refers to policies not bonds and is not intended to apply to surety bonds.

Comment No.: **11**
Section: **2695.1(f)**
Commentator: Jeffrey J. Fuller, Association of California Insurance Companies
Date of Comment: May 7 and 8, 2002
Type of Comment: Written and Oral

Summary of Comment: This subsection is an attempt to elevate regulations above the legal force and effect of the statutes being implemented. The substance of this mandate is found no where in statute.

Response to Comment: The commissioner has considered the comment and rejects it. The proposed section, reflecting the language contained in the Unfair Practices Act, does not mandate what language must be contained in a policy. Rather, the section specifies that provisions in a policy relating to adjustment of claims must either be consistent with or more favorable to the insured than the regulations.

Insurance Code Section 790.03(h) enumerates 16 unfair claims practices that an insurer is prohibited from performing. These regulations do not dictate policy language but set forth the minimum standards that an insurer must adhere to when processing claims. The commissioner has the authority to prohibit policy provisions that would result in unfair claims practices. The language of some policy provisions is in direct conflict with these regulations and, when applied to a claim, would result in a violation of these regulations and Section 790.03(h). As an example, it is an unfair claims practice to "require" an insured to have his/her auto repaired in a particular auto body shop. An insurer is prohibited from having a policy provision that places this requirement on the insured.

However, in light of all comments regarding this section, the Commissioner has clarified the proposed regulation as follows:

> **(f) ~~Provisions of all policies delivered or issued in this state~~ Policy provisions relating to the investigation, processing and settlement of claims shall be consistent with or more favorable to the insured than the provisions of these regulations.**

Comment No.: **35**
Section: **2695.1(f)**
Commentator: Kent Keller, Barger and Wolen, on behalf of 21st Century Insurance Company
Date of Comment: May 7 and 8, 2002
Type of Comment: Written and Oral

Summary of Comment: Where the Legislature has determined that mandatory policy provisions are warranted, it has enacted legislation to mandate such provisions. The statutes under the Unfair Practices Act ("the Act") do not give the Department authority to dictate policy provisions. The 16 unfair practices listed under the Act regulate the insurer's procedures in handling claims as opposed to the benefits provided by policy. Therefore, the Department has no authority to promulgate a regulation requiring insurance policies to contain specified benefits.

Response to Comment: The Commissioner has considered and rejects this comment. The proposed amendment does not mandate what provisions must be contained in insurance policies but specifies that provisions in a policy that relate to adjustment of claims must either be consistent with or more favorable to the insured than the regulations. In other words, policy terms must comply with the law.

Insurance Code Section 790.03(h) enumerates 16 unfair claims practices that an insurer is prohibited from performing. Contrary to the commentator's assertion, these regulations do not dictate coverage or mandate policy provisions. The regulations set forth the minimum standards that an insurer must adhere to when processing claims. The commissioner has the authority to prohibit policy provisions that would result in unfair claims practices. The language of some policy provisions is in direct conflict with these regulations and, when applied to a claim, would result in a violation of these regulations and Section 790.03(h). As an example, it is an unfair claims practice to "require" an insured to have his/her auto repaired in a particular auto body shop. An insurer is prohibited from having a policy provision that places this requirement on the insured.

However, in light of these and other similar comments, the Commissioner has clarified the proposed regulation as follows:

> **(f) ~~Provisions of all policies delivered or issued in this state~~ Policy provisions relating to the investigation, processing and settlement of claims shall be consistent with or more favorable to the insured than the provisions of these regulations.**

Comment No.: **29**
Section: **2695.1(f)**
Commentator: Steve McManus, State Farm Insurance Companies

Date of Comment: May 9, 2002
Type of Comment: Written

Summary of Comment: The Department is not authorized by law to mandate insurers to provide specific benefits or establish minimum policy standards. Insurance Code Section 790 regulates insurer practices not policy language.

Response to Comment: Response to Comment: The Commissioner has considered and rejects this comment. The proposed amendment does not mandate what provisions must be contained in insurance policies but specifies that provisions in a policy that relate to adjustment of claims must either be consistent with or more favorable to the insured than the regulations. In other words, policy terms must comply with the law.

Insurance Code Section 790.03(h) enumerates 16 unfair claims practices that an insurer is prohibited from performing. Contrary to the commentator's assertion, these regulations do not dictate coverage or mandate policy provisions. The regulations set forth the minimum standards that an insurer must adhere to when processing claims. The commissioner has the authority to prohibit policy provisions that would result in unfair claims practices. The language of some policy provisions is in direct conflict with these regulations and, when applied to a claim, would result in a violation of these regulations and Section 790.03(h). As an example, it is an unfair claims practice to "require" an insured to have his/her auto repaired in a particular auto body shop. An insurer is prohibited from having a policy provision that places this requirement on the insured.

However, in light of these and other similar comments, the Commissioner has clarified the proposed regulation as follows:

> **(f) ~~Provisions of all policies delivered or issued in this state~~ Policy provisions relating to the investigation, processing and settlement of claims shall be consistent with or more favorable to the insured than the provisions of these regulations.**

Comment No.: Oral - See Transcript in Rulemaking File
Section: 2695.1(f)
Commentator: Gary Hernandez, Sonnenschein, Nath & Rosenthal
Date of Comment: May 8, 2002
Type of Comment: Oral

Summary of Comment: This provision requires that, regardless of the terms of their policy, insurer using advisory organization language or their own language would have to modify the contract to be consistent with the regulations. To the extent such modifications would require companies to use forms different than those already approved by the Department's rate filing bureau, the Department invites confusion and inconsistency. The Commissioner does not have the authority to require insurers to include certain language in their policy.

Response to Comment: The Commissioner has considered and rejects this comment. The proposed amendment does not mandate what provisions must be contained in insurance policies but specifies that provisions in a policy that relate to adjustment of claims must either be consistent with or more favorable to the insured than the regulations. In other words, policy terms must comply with the law.

Insurance Code Section 790.03(h) enumerates 16 unfair claims practices that an insurer is prohibited from performing. Contrary to the commentator's assertion, these regulations do not dictate coverage or mandate policy provisions. The regulations set forth the minimum standards that an insurer must adhere to when processing claims. The commissioner has the authority to prohibit policy provisions that would result in unfair claims practices. The language of some policy provisions is in direct conflict with these regulations and, when applied to a claim, would result in a violation of these regulations and Section 790.03(h). As an example, it is an unfair claims practice to "require" an insured to have his/her auto repaired in a particular auto body shop. An insurer is prohibited from having a policy provision that places this requirement on the insured.

However, in light of these and other similar comments, the Commissioner has clarified the proposed regulation as follows:

> **(f) ~~Provisions of all policies delivered or issued in this state~~ Policy provisions relating to the investigation, processing and settlement of claims shall be consistent with or more favorable to the insured than the provisions of these regulations.**

Comments RE: Section 2695.2, generally

Comment No.: **4**
Section: **2695.2, generally**
Commentator: John Metz
Date of Comment: April 24 and May 8, 2002
Type of Comment: Written and Oral

1. Summary of Comment: The regulations should be amended to add a definition of "accepting a claim" or "acceptance of a claim."

Response to Comment: This comment is rejected as it falls outside the scope of the proposed rulemaking.

2. Summary of Comment: The regulations should be amended to add a definition of "insured."

Response to Comment: This comment is rejected as it falls outside the scope of the proposed rulemaking.

3. Summary of Comment: The regulations should be amended to add a definition of "know" and "knowledge."

Response to Comment: This comment is rejected as it falls outside the scope of the proposed rulemaking.

4. Summary of Comment: The definition of "Licensee" should specify that underwritten title companies are not included within the definition if the underwritten title company is not authorized to handle policy claims on behalf of the title insurer and this fact has been disclosed in writing to the policyholder at the time the policy was sold.

Response to Comment: This comment is rejected as it falls outside the scope of the proposed rulemaking.

5. Summary of Comment: The definition of "Notice of claim" should include notification to an insurer or its agent "from any source" that reasonably apprises the insurer that the claimant wishes to make a claim.

Response to Comment: This comment is rejected as it falls outside the scope of the proposed rulemaking.

6. Summary of Comment: Written or oral communications provided to the insurer that state that they are being provided for informational or incident reporting purposes only are not to be included within the definition of "Notice of claim." In such instances, the insurer must also inform the insured in writing that he/she has not met the notice of claim requirements.

Response to Comment: This comment is rejected as it falls outside the scope of the proposed rulemaking.

7. Summary of Comment: The commentator suggests adding to the definition of "Remedial measures."

Response to Comment: This comment is rejected as it falls outside the scope of the proposed rulemaking.

Comments RE: Section 2695.2(a)

Comment No.: **4**
Section: **2695.2(a)**
Commentator: John Metz
Date of Comment: April 24 and May 8, 2002
Type of Comment: Written and Oral

Summary of Comment: The definition of "Beneficiary" should be expanded in connection with property and casualty insurance claims.
Response to Comment: This comment is rejected as it falls outside the scope of the proposed rulemaking.

Comments RE: Section 2695.2(c)

Comment No.: **4**
Section: **2695.2(c)**
Commentator: John Metz
Date of Comment: April 24 and May 8, 2002
Type of Comment: Written and Oral

Summary of Comment: The definition of "Claimant" should include the term "beneficiary."

Response to Comment: This comment is rejected as it falls outside the scope of the proposed rulemaking.

Comments RE: Section 2695.2(d)(1)

Comment No.: **4**
Section: **2695.2(d)(1)**
Commentator: John Metz
Date of Comment: April 24 and May 8, 2002
Type of Comment: Written and Oral

Summary of Comment: Attorneys should be exempted from the definition of "Claims agent" only during the period the attorney is actually involved in defending a claim brought against an insured.

Response to Comment: This comment is rejected as it falls outside the scope of the proposed rulemaking.

Comments RE: Section 2695.2(d)(2)

Comment No.: **4**
Section: **2695.2(d)(2)**
Commentator: John Metz
Date of Comment: April 24 and May 8, 2002
Type of Comment: Written and Oral

Summary of Comment: Persons hired by an insurer to provide valuation services should be exempted from the definition of "Claims agent" when the valuations do not include an interpretation of policy provisions or law and are free from bias.

Response to Comment: This comment is rejected as it falls outside the scope of the proposed rulemaking.

Comments RE: Section 2695.2(i)

Comment No.: **9**
Section: **2695.2(i)**
Commentator: Sean E. McCarthy, Stoel Rives LLP, on behalf of Home Warranty Association of California ("HWAC")
Date of Comment: May 7, 2002
Type of Comment: Written

Summary of Comment: Home protection companies should not be included within this subsection's definition of "insurer."

Response to Comment: The Commissioner has considered this comment and rejects it. Pursuant to Section 12743(j)(1) and (4), the term "insurer," when used in Section 790 et seq., means home protection company. These regulations were promulgated pursuant to the authority of Insurance Code Section790.10 (which also applies to home protection companies.) As

Insurance Code Section 12743(k) specifies, in the event of any conflict between the Unfair Practices Act and the Home Protection Act (commencing with Insurance Code Section 12740), the Home Protection Act prevails.

Comment No.: **33**
Section: **2695.2(i)**
Commentator: George Spaeth, Spaeth & McGraw, on behalf of Buyers Home Warranty Company
Date of Comment: May 9, 2002
Type of Comment: Written

Summary of Comment: Home protection companies should not be included within this subsection's definition of "insurer."

Response to Comment: The Commissioner has considered this comment and rejects it. Pursuant to Section 12743(j)(1) and (4), the term "insurer," when used in Section 790 et seq., means home protection company. These regulations were promulgated pursuant to the authority of Insurance Code Section 790.10
(which also applies to home protection companies.) As Insurance Code Section 12743(k) specifies, in the event of any conflict between the Unfair Practices Act and the Home Protection Act (commencing with Insurance Code Section 12740), the Home Protection Act prevails.

Comments RE: Section 2695.2(j)

Comment No.: **15**
Section: **2695.2(j)**
Commentator: Marilyn Klinger; Sedgwick, Detert, Moran & Arnold on behalf of The Surety Association of America
Date of Comment: May 8, 2002
Type of Comment: Written and Oral

Summary of Comment: By this proposed amendment, the regulations would include sureties in with other insurers for purposes of Section 2695.7. As such, our comments with respect to Section 2695.7 apply equally to this proposed amendment.

Response to Comment: The commentator is referred to the Commissioner's responses to Section 2695.7.

Comments RE: Section 2695.2(k)

Comment No.: **4**
Section: **2695.2(k)**
Commentator: John Metz
Date of Comment: April 24 and May 8, 2002
Type of Comment: Written and Oral

Summary of Comment: This section should be amended to clarify that an insurer's duty to investigate is triggered by knowledge of facts that might result in a finding of coverage. The

current wording could be interpreted to suggest that the cost of an investigation might have to be borne by the claimant.

Response to Comment: The Commissioner has considered this comment and rejects it. The current wording could in no way be interpreted to suggest that the cost of an investigation might have to be borne by the claimant.

Comments RE: Section 2695.2(l)

Comment No.: **29**
Section: **2695.2(l)**
Commentator: Steve McManus, State Farm Insurance Companies
Date of Comment: May 9, 2002
Type of Comment: Written

Summary of Comment: By deleting language in Section 2695.12 and amending the subject definition to "knowingly", the regulations now imply that all violations were knowingly committed or intentional. The majority of an insurer's conduct in the market complies with the law. Instances of noncompliance are likely unintentional and not knowingly committed. The proposed definition is not authorized by statute and is inconsistent with Insurance Code Section 790.03(h).

Response to Comment: The Commissioner has considered this comment and rejects it. If an act that is knowingly committed on a single occasion or performed as a business practice is not in compliance with the regulations, it is necessarily in violation of the regulations. If the insurer has actual, implied or constructive knowledge that it is committing an act, even if it does not know that it is committing a violation of the Insurance Code, it is still a violation.

The issue then becomes whether the knowingly committed act or business practice was willful or nonwillful, i.e., whether the insurer knew when the act was committed that it was a violation of the Insurance Code. The willfulness or nonwillfulness would affect the amount of penalty to be assessed pursuant to Insurance Code Section 790.035.

Comments RE: Section 2695.2(n)

Comment No.: **19**
Section: **2695.2(n)**
Commentator: Amy Bach, Executive Director, United Policyholders
Date of Comment: May 8, 2002
Type of Comment: Written

Summary of Comment: The definition of "Notice of claim" should be amended to include written or oral notification to an insurer or its agent "from any source."

Response to Comment. This comment falls outside the scope of the proposed amendments and will not be considered.

Comment No. : **25**

Section: **2695.2(n)**
Commentator: Norma P. Garcia, Senior Attorney, Consumers Union
Date of Comment: May 9, 2002
Type of Comment: Written

Summary of Comment: Reiterates United Policyholders' comment that the definition of Notice of claim" should be amended to include written or oral notification to an insurer or its agent "from any source."

Response to Comment. This comment falls outside the scope of the proposed amendments and will not be considered.

Comments RE: Section 2695.2(s)

Comment No.: **28**
Section: **2695.2(s)**
Commentator: Douglas A. Lutgen, CSAA Inter-Insurance Bureau
Date of Comment: May 9, 2002
Type of Comment: Written

1. Summary of Comment: The addition of the term "evidence" does not promote clarity or consistency, as it creates an ambiguity. "Evidence" can be just about anything, including oral hearsay.

Response to Comment: The Commissioner has considered the proposed comment and rejects it. The word "evidence" is not ambiguous as the definition specifies that not just any evidence will be considered part of proof of claim but only evidence that "reasonably supports the claim."

2. Summary of Comment: The proposed amended definition of "proof of claim" includes evidence or documentation in the claimant's possession but which has not been submitted to or received by the insurer. The insurer cannot be expected to know about evidence in the claimant's possession that the claimant has not provided to the insurer.

Response to Comment: The Commissioner has considered this comment and accepts it. The commissioner agrees that evidence or documentation in the claimant's possession must be submitted to the insurer in order for it to be included as "proof of claim." The proposed amendment to Section 2695.2(s) now reads as follows:

(s) "Proof of claim" means any **evidence or** documentation in the claimant's possession **or any evidence** submitted to **or received by** the insurer **or other evidence that the insurer discovers in the course of its investigation** ~~which provides any evidence of the claim and~~ that **reasonably** supports the **claim** ~~magnitude or the amount of the claimed loss~~.

3. Summary of Comment: Deletion of the phrase "magnitude or the amount of the claimed loss" creates ambiguity because it leaves as the operative concept the phrase "supports the claim." No definition or guidance is given as to what type or volume of information is required to "support" the claim.

Response to Comment: The Commissioner has considered this comment and rejects it. The words "magnitude or the amount of the claimed loss" are necessarily part of what constitutes a claim. The insurer would not have to accept a claim unless the evidence or documentation submitted supported the claim. As such, the words "magnitude or the amount of the claimed loss" are unnecessary verbiage.

Comment No.: **13**
Section: **2695.2(s)**
Commentator: G. Diane Colborn, Personal Insurance Federation of California
Date of Comment: May 7 and 8, 2002
Type of Comment: Written and Oral

1. Summary of Comment: The proposed amended definition of "proof of claim" includes evidence or documentation in the claimant's possession but which has not been submitted to or received by the insurer. The insurer cannot be expected to know about evidence in the claimant's possession that the claimant has not provided to the insurer.

Response to Comment: The Commissioner has considered this comment and accepts it. The commissioner agrees that evidence or documentation in the claimant's possession must be submitted to the insurer in order for it to be included as "proof of claim." The proposed amendment to Section 2695.2(s) now reads as follows:

(s) "Proof of claim" means any **evidence or** documentation in the claimant's possession **or any evidence** submitted to **or received by** the insurer **or other evidence that the insurer discovers in the course of its investigation** ~~which provides any evidence of the claim and~~ that **reasonably** supports the **claim** ~~magnitude or the amount of the claimed loss~~.

2. Summary of Comment: The deletion of the words "magnitude or the amount of the claimed loss" without further clarification as to what is meant by "any evidence" is vague and ambiguous.

Response to Comment: The Commissioner has considered this comment and rejects it. The words "magnitude or the amount of the claimed loss" are necessarily part of what constitutes a claim. The insurer would not have to accept a claim unless the evidence or documentation submitted supported the claim. As such, the words "magnitude or the amount of the claimed loss" are unnecessary verbiage.

Comment No. : **38**
Section: **2695.2(s)**
Commentator: Bill Gausewitz, American Insurance Association
Date of Comment: May 9, 2002
Type of Comment: Written

Summary of Comment: The phrase "or any evidence" is ambiguous as it is unclear whether documentation in a claimant's possession must be submitted to or received by an insurer before becoming a basis for proving a claim.

Response to Comment: The Commissioner has considered this comment and accepts it. Evidence or documentation in the claimant's possession must be submitted to the insurer in order

for it to be included as "proof of claim." The proposed amendment to Section 2695.2(s) now reads as follows:

(s) "Proof of claim" means any **evidence or** documentation in the claimant's possession **or any evidence** submitted to **or received by** the insurer **or other evidence that the insurer discovers in the course of its investigation** ~~which provides any evidence of the claim and~~ that **reasonably** supports the **claim** ~~magnitude or the amount of the claimed loss~~.

Comment No.: 18
Section: 2695.2(s)
Commentator: Samuel Sorich, National Association of Independent Insurers
Date of Comment: May 8, 2002
Type of Comment: Oral and Written

1. Summary of Comment: The proposed amendments violate the regulatory standards of clarity and consistency. First, under the proposed amendments, proof of claim includes "any evidence or documentation in the claimant's possession." This means that, even if no evidence or documentation was in the insurer's possession (but, rather, only in the claimant's possession), the insurer would be obligated to accept or deny the claim.

Response to Comment: The Commissioner has considered the comment and accepts it. Evidence or documentation in the claimant's possession must be submitted to the insurer in order for it to be included as "proof of claim."

The proposed amendment to Section 2695.2(s) now reads:

(s) "Proof of claim" means any **evidence or** documentation in the claimant's possession **or any evidence** submitted to **or received by** the insurer **or other evidence that the insurer discovers in the course of its investigation** ~~which provides any evidence of the claim and~~ that **reasonably** supports the **claim** ~~magnitude or the amount of the claimed loss~~.

2. Summary of Comment: The proposed amendments add the term "evidence" to the definition of "proof of claim." "Evidence" is an ambiguous word that creates uncertainty, making it difficult for an insurer to assure compliance and would subject an insurer to arbitrary, inconsistent compliance.

Response to Comment: The Commissioner has considered the proposed comment and rejects it. The word "evidence" is not ambiguous as the definition specifies that not just any evidence will be considered part of proof of claim but only evidence that "reasonably supports the claim."

3. Summary of Comment: The deletion of the words "the magnitude or the amount of the claimed loss" from the definition of "proof of claim" creates an inconsistency between Section 2695.2(s) and 2695.7 because an insurer would be obliged to accept a claim and make a payment even though there is no evidence or documentation as to the magnitude or amount of the claimed loss.

Response to Comment: The words "magnitude or the amount of the claimed loss" are necessarily part of what constitutes a claim. In other words, the insurer would not have to accept

a claim unless the evidence or documentation submitted supported the claim. As such, the words "magnitude or the amount of the claimed loss" are unnecessary verbiage.

4. Summary of Comment: The proposed amendments to this section blur the distinction between "proof of claim" in Section 2695.2(s) and "notice of claim" in Section 2695.2(n).

Response to Comment: The proposed amendment, as set forth below, does not blur the separate and distinct concepts and definitions of "notice of claim" and "proof of claim." "Notice of claim" in Section 2695.2(n) means: "any written or oral notification to an insurer or its agent that reasonably apprises the insurer that the claimant wishes to make a claim…and that a condition giving rise to the insurer's obligations under that policy or bond may have arisen."(Emphasis added.) The Section 2695.2(s) definition of "proof of claim", as revised above, (see Response to Samuel Sorich, above) refers to "any evidence or documentation submitted to or received by the insurer that reasonably supports the claim." (Emphasis added.)

Comment No. : **17**
Section: **2695.2(s)**
Commentator: Douglas K. deVries, Mart & deVries**:** Joined by Lea-Ann Tratten, Consumer Attorneys of California
Date of Comment: May 8, 2002
Type of Comment: Written

Summary of Comment: The Department's stated reason for changes to this section is to assure that information an insurer has access to but that is not in the claimant's possession will also be considered and not discounted just because it did not come from the claimant. I do not believe that the change necessarily accomplishes this goal and may actually have a contrary effect.

Response to Comment: The commissioner has considered this comment and accepts it. The proposed amendment to Section 2695.2(s) now reads:

(s) "Proof of claim" means any **evidence or** documentation in the claimant's possession **or any evidence** submitted to **or received by** the insurer **or other evidence that the insurer discovers in the course of its investigation** ~~which provides any evidence of the claim and~~ that **reasonably** supports the **claim** ~~magnitude or the amount of the claimed loss~~.

Comment No. : **37**
Section: **2695.2(s)**
Commentator: Bennett L. Katz, Farmers Insurance Group
Date of Comment: May 8, 2002
Type of Comment: Written

Summary of Comment: The proposed amendment is not reasonably necessary to effectuate the purpose of the statute. The current regulation is equally as or more effective than the amendment, since it appropriately places the burden to submit documentation to support "proof of claim" on the claimant.

Response to Comment: The Commissioner has considered this comment and rejects it. The insurer may have access to information that supports the claim but is not in the claimant's

possession. This information should also be considered by the insurer and should not be discounted just because it does not come from the claimant.

Comment No.: **11**
Section: **2695.2(s)**
Commentator: Jeffrey J. Fuller, Association of California Insurance Companies
Date of Comment: May 7 and 8, 2002
Type of Comment: Written and Oral

1. Summary of Comment: This section would impose an unthinkable burden on insurers to be aware of evidence which is in the claimant's possession but is not submitted to the insurer in support of the claim.

Response to Comment: The proposed amendment, as set forth below, does not blur the separate and distinct concepts and definitions of "notice of claim" and "proof of claim." "Notice of claim" in Section 2695.2(n) means: "any written or oral notification to an insurer or its agent that reasonably apprises the insurer that the claimant wishes to make a claim…and that a condition giving rise to the insurer's obligations under that policy or bond may have arisen."(Emphasis added.) The Section 2695.2(s) definition of "proof of claim", as revised above, (see Response to Samuel Sorich, above) refers to "any evidence or documentation submitted to or received by the insurer that reasonably supports the claim." (Emphasis added.)

2. Summary of Comment: The term "reasonably supports" lacks clarity and is ambiguous. "Proof of claim" should include a reference to the amount owed to the claimant since the claim must be paid within thirty days once it is accepted by the insurer.

Response to Comment: The Commissioner has considered this comment and rejects it. The insurer should consider documentation/evidence submitted to or received by the insurer from the claimant or other source that supports the claim. The insurer should consider the documentation/evidence even if it does not specify the amount owed. The words "reasonably support" were added as they provide more clarity than the words "which provides any evidence of the claim".

Comment No.: **35**
Section: **2695.2(s)**
Commentator: Kent Keller, Barger and Wolen, on behalf of 21st Century Insurance Company
Date of Comment: May 7 and 8, 2002
Type of Comment: Written and Oral

1. Summary of Comment: The governing statute for this section, Insurance Code Section 790.03(h)(4), defines as an unfair practice "failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been **completed and submitted by the insured**."(Emphasis added.) The proposed amendment expands the definition of "proof of claim" in that it (1) includes any evidence, whether documented or not, from any source, and (2) strips the insurer of its discretion to set proof of loss rules in the policy (such as that proof of loss must be submitted by the insured.)

Response to Comment: The Commissioner has considered this comment and rejects it. Insurance Code Section 790.03(h)(2) lists as an unfair practice "[f]ailing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies." If the insurer has access to information that supports a claim, the insurer should consider this information regardless of whether it comes from the claimant.

2. Summary of Comment: The Department's proposal muddles the investigation process in two ways. First, it eliminates the requirement that the proof of claim consist of documentation. Second, it deletes the requirement that the proof of claim support the "magnitude or amount" of the claim. The result is that the new definition would only require oral evidence that reasonably supports the claim. These changes essentially make a "proof of claim" equivalent to notice of claim, creating an unbalanced claim process where the insurer must prematurely accept or deny the claim before evidence of damages is received and possibly before liability has been determined at all.

Response to Comment: The Commissioner has considered this comment and rejects it. The proposed amendment, as set forth below, does not blur the separate and distinct concepts and definitions of "notice of claim" and "proof of claim." "Notice of claim" in Section 2695.2(n) means: "any written or oral notification to an insurer or its agent that reasonably apprises the insurer that the claimant wishes to make a claim…and that a condition giving rise to the insurer's obligations under that policy or bond may have arisen."(Emphasis added.) Section 2695.2(s) definition of "proof of claim", as revised above, (see Response to Comment below) refers to "any evidence or documentation submitted to or received by the insurer that reasonably supports the claim." (Emphasis added.)

3. Summary of Comment: The proposed amendment is unclear as it could be read to allow proof of claim to include evidence or documentation in the claimant's possession that has not been received by the insurer.

Response to Comment: The Commissioner has considered the comment and accepts it. Evidence or documentation in the claimant's possession must be submitted to the insurer in order for it to be included as "proof of claim."

The proposed amendment to Section 2695.2(s) now reads:

(s) "Proof of claim" means any **evidence or** documentation in the claimant's possession **or any evidence** submitted to **or received by** the insurer **or other evidence that the insurer discovers in the course of its investigation** ~~which provides any evidence of the claim and~~ that **reasonably** supports the **claim** ~~magnitude or the amount of the claimed loss~~.

Comment No.: **29**
Section: **2695.2(s)**
Commentator: Steve McManus, State Farm Insurance Companies
Date of Comment: May 9, 2002
Type of Comment: Written

1. Summary of Comment: The revised definition would make insurers responsible for items in a claimant's possession that have not been submitted to an insurer.

Response to Comment: The Commissioner has considered the comment and accepts it. Evidence or documentation in the claimant's possession must be submitted to the insurer in order for it to be included as "proof of claim."

The proposed amendment to Section 2695.2(s) now reads:

(s) "Proof of claim" means any **evidence or** documentation in the claimant's possession **or any evidence** submitted to **or received by** the insurer **or other evidence that the insurer discovers in the course of its investigation** ~~which provides any evidence of the claim and~~ that **reasonably** supports the **claim** ~~magnitude or the amount of the claimed loss~~.

2. Summary of Comment: The drafters have blended the meanings of "proof of claim" and "notice of claim." The phrase "magnitude or the amount of the claim loss" should not be deleted.

Response to Comment: The Commissioner has considered this comment and rejects it. The proposed amendment, as set forth below, does not blur the separate and distinct concepts and definitions of "notice of claim" and "proof of claim." "Notice of claim" in Section 2695.2(n) means: "any written or oral notification to an insurer or its agent that reasonably apprises the insurer that the claimant wishes to make a claim…and that a condition giving rise to the insurer's obligations under that policy or bond may have arisen."(Emphasis added.) Section 2695.2(s) definition of "proof of claim", as revised above, refers to "any evidence or documentation submitted to or received by the insurer that reasonably supports the claim." (Emphasis added.)

3. Summary of Comment: The term "evidence" is used without authorization and its use creates a lack of clarity.

Response to Comment: The Commissioner has considered the proposed comment and rejects it. The Commissioner does not need statutory authority to use a word in the dictionary. Furthermore, use of the word "evidence", defined as "the data on which a judgment or conclusion may be based; something that furnishes proof" (The American Heritage Dictionary, Second College Edition) does not create a lack of clarity. The definition specifies that not just any evidence will be considered part of proof of claim but only evidence that "reasonably supports the claim."

Comment No.: **4**
Section: **2695.2(s)**
Commentator: John Metz
Date of Comment: April 24 and May 8, 2002
Type of Comment: Written and Oral

Summary of Comment: "Proof of claim" should include evidence that the insurer discovers or should discover in the course of its investigation.

Response to Comment: The Commissioner has considered this comment and accepts it in part and rejects it in part. The Commissioner agrees that "proof of claim" should include evidence that the insurer discovers during the course of its investigation. However, an insurer's failure to discover evidence that it should have discovered constitutes a failure to investigate in violation of Section 2695.7(d). This section shall now read:

(s) "Proof of claim" means any **evidence or** documentation in the claimant's possession **or any evidence** submitted to **or received by** the insurer **or other evidence that the insurer discovers in the course of its investigation** ~~which provides any evidence of the claim and~~ that **reasonably** supports the **claim** ~~magnitude or the amount of the claimed loss~~.

Comment No.: **Oral - See Transcript in Rulemaking File**
Section: **2695.2(s)**
Commentator: Gary Hernandez, Sonnenschein, Nath & Rosenthal
Date of Comment: May 8, 2002
Type of Comment: Oral

Summary of Comment: The proposed revision makes the definition of "proof of claim" vague.

Response to Comment: See the revised language above (Response to John Metz comment number 4).

Comments Re: SECTION 2695.3

Comment No.: **4**
Section: **2695.3**
Commentator: John Metz
Date of comment: 4/30/02
Type of comment: Written & Oral

Summary of comment: Recommends several changes to this subsection.

Response to comment: The commissioner considered the comment and rejects it. The comment is outside the scope of the rulemaking.

Comments Re: SECTION 2695.4(a)

Comment Nos.: **13, 18, 28, 11**
Section: **2695.4(a)**
Commentator: G. Diane Colborn, Personal Insurance Federation
Date: May 7, 2002
Type of Comment: Written
Also commented by: Samuel Sorich, National Association of Independent Insurers
Date: May 8, 2002
Type of Comment: Written
Also commented by: Douglas A. Lutgen, California State Automobile Association Inter-Insurance Bureau
Date: May 9, 2002
Type of Comment: Written
Also commented by: Gary Hernandez, Sonnenschein, Nath & Rosenthal
Date: May 8, 2002
Type of Comment: Oral - See Transcript in Rulemaking File

Also commented by: Jeffrey J. Fuller, Association of California Insurance Companies (ACIC)
Date: May 8, 2002
Type of Comment: Oral - See Transcript in Rulemaking File

1. Summary of Comment: Requiring an insurer to inform a claimant or beneficiary of "any pertinent statutes and regulations that the insurer relies upon to process the claim" is requiring the insurer to provide legal advice. It is outside the scope of the commissioner's jurisdiction and authority to do so. Moreover, it exceeds the insurer's duty under an insurance policy, which is to reasonably inform an insured of his or her rights and obligations under the policy.

Response to Comment: The commissioner has considered the comment and rejects it. The requirement is to provide information, not advice or counsel. The information to be provided already is, or should be, within the knowledge of those who provide training in claims handling.

Moreover, it is within the commissioner's jurisdiction and authority to establish and enforce minimum standards for fair claims settlement practices. (Ins. Code, §790.10*; Moradi-Shalal v. Fireman's Fund Ins. Cos.* (1988) 46 Cal. 3d 287 [250 Cal.Rptr. 116].)

The intent of insurers should be to shed light on the factors necessary to the claims settlement process so that (1) claimants will be adequately apprised of their rights and obligations, and (2) litigation might be avoided through claimants' and beneficiaries' better understanding of the process.

2. Summary of Comment: It is not within the commissioner's authority to decide legal disputes such as what may be a legitimate difference of opinion between an insurer and a third party beneficiary regarding the applicability or interpretation of a statute.

Response to Comment: The commissioner has considered the comment and rejects it. Nothing contained in the proposed regulations requires or authorizes the commissioner to determine liability in a third party claim. It is within the commissioner's authority, however, to determine whether an insurer's application or interpretation of a statute in the Insurance Code is reasonable.

3. Summary of Comment: This requirement places insurance claims adjusters in the position of engaging in the unauthorized practice of law and providing legal counsel to claimants.

Response to Comment: The commissioner has considered the comment and rejects it. The requirement is to provide information, not advice or counsel. The information to be provided already is, or should be, within the knowledge of those who provide training in claims handling.

4. Summary of Comment: This provision would substantially increase claims costs by necessitating that every claim be referred to an attorney for a legal opinion as to applicable statutes. Moreover, the language of the provision could be interpreted to require insurers to provide legal analyses and attorney work product, i.e., privileged information, since the language refers to statutes and regulations "the insurer relies upon."

Response to Comment: The commissioner has considered the comment and rejects it. Referral of claims to insurers' attorneys will be no more necessary with this requirement than it

is now. The requirement does not include disclosing legal opinions, legal analyses, attorney work-product or any other privileged information.

Comment Nos.: **35, 29, 11,**
Section: **2695.4(a)**
Commentator: Kent R. Keller and Robert W. Hogeboom, Barger & Wolen LLP, for 21st Century Insurance Company
Date: May 7, 2002
Type of Comment: Written
Also commented by: Steve McManus, State Farm Insurance Companies
Date: May 9, 2002
Type of Comment: Written
Also commented by: Jeffrey J. Fuller, Association of California Insurance Companies (ACIC)
Date: May 7, 2002
Type of Comment: Written

1. Summary of Comment: The requirement to disclose "any pertinent statutes and regulations that the insurer relies upon to process the claim" conflicts with the Unfair Practice's Act's disclosure provisions, is not authorized by statute and would improperly expand insurers' disclosure obligations to every law and regulation touching on the claims process. It would require insurers to make legal representations and potentially disclose privileged material. It does not meet the Government Code's standards of authority, consistency and necessity.

Response to Comment: The commissioner has considered the comment and rejects it. It is within the commissioner's jurisdiction and authority to establish and enforce minimum standards for fair claims settlement practices. (Ins. Code, §790.10*; Moradi-Shalal v. Fireman's Fund Ins. Cos.* (1988) 46 Cal. 3d 287 [250 Cal.Rptr. 116].)

The intent of insurers should be to shed light on the factors necessary to the claims settlement process so that (1) claimants will be adequately apprised of their rights and obligations, and (2) litigation might be avoided through claimants' and beneficiaries' better understanding of the process.

2. Summary of Comment: The requirement to disclose "any pertinent statutes and regulations that the insurer relies upon to process the claim" would set an impossible standard for insurers, requiring them in effect to practice law. The claims process is subject to a multitude of statutes and regulations. It is an unreasonable and impossible burden to require insurers to determine all applicable statutory and regulatory provisions and disclose them to the insured. It would force claims employees to have legal knowledge beyond their training, and would improperly require insurers to practice law in violation of Section 625 of the Business and Professions Code. It would also subject insurers to numerous citations in market conduct examinations.

Response to Comment: The commissioner has considered the comment and rejects it. It is within the commissioner's jurisdiction and authority to establish and enforce minimum standards for fair claims settlement practices. (Ins. Code, §790.10*; Moradi-Shalal v. Fireman's Fund Ins. Cos.* (1988) 46 Cal. 3d 287 [250 Cal.Rptr. 116].) The commissioner believes it should be the intent of insurers to shed light on the factors necessary to the claims settlement process so that (1) claimants will be adequately apprised of their rights and obligations, and (2) litigation might be avoided through claimants' and beneficiaries' better understanding of the process.

Insurers and their attorneys are knowledgable as to the statutes and regulations to which they are subject and which may apply to the different classes of claims submitted to them. The insurance policy is a contract of adhesion, the terms of which the insurer has knowledge and understanding superior to that of the insured. The proposed language will impose no more of a burden than it is to communicate that knowledge to their claims employees.

Finally, the proposed change will not subject insurers to any new citations if they comply with the regulation.

3. Summary of Comment: The requirement to advise the insured of *all* policy provisions the insurer relies on to process the claim does not meet the standard of necessity. The insured already has the insurance policy setting forth all coverages, benefits and limitations. The language of a contract is to govern its interpretation (Civ. Code, §1638), with the mutual intention of the parties to be inferred, if possible, solely from the written provisions of the contract (*AIU Ins. Co. v. Superior Court (FMC Corp.)* (1990) 51 Cal.3d 807, 821-822). Moreover, insureds are charged with knowledge of clear and conspicuous policy provisions. (See *Hackethal v. National Casualty Company* (1987) 189 Cal.App.3d 1102, 1111-1112.)

Response to Comment: The commissioner has considered the comment and rejects it. The insurance policy is a contract of adhesion, the terms of which the insurer has knowledge and understanding superior to that of the insured. ("[E]ven the courts have recognized that few if any terms of an insurance policy can be clearly and completely understood by persons untrained in insurance law." *Clement v. Smith* (1993) 16 Cal. App. 4th 39, 45; also see *Raulet v. Northwestern etc. Ins. Co.* (1910) 157 Cal.213, 230; *Wyatt v. Union Mortgage Co.* (1979) 24 Cal.3d 773, 783.) Insurers and their attorneys are knowledgable as to the statutes and regulations to which they are subject and which may apply to the different classes of claims submitted to them. The proposed language will impose no more of a burden than it is to communicate that knowledge to their claims employees.

4. Summary of Comment: The requirement to advise the insured of *all* policy provisions the insurer relies on to process the claim does not meet the standard of authority. The Unfair Practices Act requires disclosure of policy provisions in only two scenarios: (1) upon request to inform the claimant of the coverage under which payment was made (Ins. Code, §790.03(h)(9)), and (2) to provide an explanation of the facts or applicable law relied on in denying a claim (Ins. Code, §790.03(h)(13)).

Response to Comment: The commissioner has considered the comment and rejects it. The commissioner is authorized to "promulgate reasonable rules and regulations, and amendments and additions thereto, as are necessary to administer this article." (Cal. Ins. Code, §790.10.) The commissioner deems the proposed regulation to be necessary to administer the article.

5. Summary of Comment: The requirement to disclose "any pertinent statutes and regulations that the insurer relies upon to process the claim" would have the effect of confusing, not informing, policyholders with an abundance of legal authority.

Response to Comment: The commissioner has considered the comment and rejects it. Policyholders who care about their claims will welcome this information.

6. Summary of Comment: If insurers are required to disclose not only statutes, but case interpretations, the amendment could require insurers to disclose legal opinions or reasoning prepared by the insurer's counsel, which would be privileged material.

Response to Comment: The commissioner has considered the comment and rejects it. The proposed language does not require disclosure of an insurer's case interpretations.

Comment No.: **11**
Section: **2695.4(a)**
Commentator: Jeffrey J. Fuller, Association of California Insurance Companies (ACIC)
Date: May 7, 2002
Type of Comment: Written

Summary of Comment: If the term "beneficiary" is intended to extend the duties in this subsection to unnamed, third-party beneficiaries, that would constitute an expansion of the regulations beyond statutory authority.

Response to Comment: The commissioner has considered the comment and rejects it. The term "beneficiary" already appears in the existing Section 2695.4(a). The meaning has not changed.

Comment No.: **18**
Section: **2695.4(a)**
Commentator: Samuel Sorich, National Association of Independent Insurers
Date: May 8, 2002
Type of Comment: Written

1. Summary of Comment: Recently enacted Senate Bill 658 requires insurers to provide claimants under homeowners insurance policies with copies of Insurance Code section 790.03(h) and the regulations. The Department does not have the authority to extend this requirement to claimants under other insurance policies. Moreover, as proposed, the requirement would be inconsistent with SB 658.

Response to Comment: The commissioner has considered the comment and rejects it. As proposed, the subsection would not require insurers to provide copies of Insurance Code section 790.03(h) or the regulations to anyone.

2. Summary of Comment: Insurance Code section 790.03(h) prohibits "knowing" misrepresentation of policy provisions. As proposed, this subsection prohibits any misrepresentation, whether knowingly made or not. Therefore, the regulation is inconsistent with the statute.

Response to Comment: The commissioner has considered the comment and rejects it. It is implicit in this subsection that an "unknowing" misrepresentation is not a violation unless it is performed so frequently as to constitute a business practice.

Comment Nos.: **17, 21, 4**
Section: **2695.4(a)**
Commentator: Douglas K. deVries, Mart & deVries, Attorneys at Law

Date: May 8, 2002
Type of Comment: Written
Also commented by: Lea-Ann Tratten, Consumer Attorneys of California
Date: May 8, 2002
Type of Comment: E-mail
Also commented by: John Metz
Date: April 30, 2002
Type of Comment: Written

Summary of Comment: The proposal changes this subsection from requiring insurers to advise first party claimants of time limits "that may apply to the claim presented by the claimant" to requiring the disclosure only of time limits "that the insurer relies upon to process the claim." This change inadvertently may undermine case law that holds that insurers are estopped to assert the statute of limitations when they do not disclose it in writing to the insured under the existing Section 2695.4(a). (*Spray, Gould & Bowers v. Associated International Ins. Co.* (1999) 71 Cal.App.4th 1260; *Neufeld v. Balboa Ins. Co.* (2000) 84 Cal.App.4th 759.) Under the new language, insurers might argue that this language eliminates the requirement that they advise insureds of the statute of limitations applicable to a claim denial in writing. The Department obviously did not intend this narrowing of the law, and there is no justification for depriving insureds of their present rights.

Response to Comment: The commissioner has considered the comment and accepts it. The subsection will be changed to read as follows:

> **(a)** ~~(b)~~ No insurer shall **misrepresent,** conceal **or fail to disclose to a first party claimant or beneficiary all** benefits, coverages**, time limits and** ~~or~~ other provisions of **any insurance policy or bond issued by the insurer,** ~~the bond~~ **and any pertinent statutes and regulations, that may apply to the claim presented or that the insurer relies upon to process the claim.** ~~which may apply to the claim presented under a surety bond.~~

Comment Nos.: 15, 38
Section: 2695.4(a)
Commentator: Marilyn Klinger, Sedgwick, Detert et al, for The Surety Association of America
Date: May 8, 2002
Type of Comment: Written and Oral
Also commented by: Bill Gausewitz, American Insurance Association
Date: May 9, 2002
Type of Comment: Written

1. Summary of Comment: The changes to existing Sections 2695.4(a) and (b) are unnecessary. An insurer drafts the policy and is more familiar with its terms than the claimant. A bond form however, is required by the obligee (beneficiary), not the surety, and is set out in an invitation for bids issued by an owner, or is prescribed by statute or the obligee. The surety does not have superior knowledge of the form or of any contractual provisions including any limitations period; therefore, it should not have an affirmative duty to disclose something that the obligee is in a better position to know.

Response to Comment: The commissioner has considered the comment and rejects it. Because a surety receives premiums and has the responsibility of determining whether it must make a payment under any bond it provides, the surety of necessity has superior knowledge and understanding of the provisions of the bonds it provides.

2. Summary of Comment: The changes to existing Sections 2695.4(a) and (b) are inconsistent with California law. The California Supreme Court, in *Cates Construction, Inc. v. Talbot Partners* (1999) 21 Cal.4th 28, held that recovery in tort is not applicable to breach of the covenant of good faith and fair dealing in a construction performance bond setting. Its reasoning was based on the differences between insurance policies and construction performance bonds, stating that

> . . . tort recovery is considered appropriate in the insurance policy setting because such contracts are characterized by elements of adhesion and unequal bargaining power, public interest and fiduciary responsibility. (*Id.*, at p. 52.)

Response to Comment: The commissioner has considered the comment and rejects it. This subsection does not affect that law, therefore it is not in conflict with *Cates.*

3. Summary of Comment: The changes to existing Sections 2695.4(a) and (b) would require the surety to provide legal advice to bond claimants. There are very few standard bond forms. Even lawyers specializing in the area have difficulty providing unequivocal advice. This is not an area of easy or clear answers, and requiring the surety to give legal advice to the claimant will not make the law any clearer.

The surety owes duties to both the obligee and the principal and should not be compelled to favor one side or the other without regard to the facts or the results of its investigation. This impartiality is inconsistent with an obligation to give advice to the claimant.

The determination of what statutes are relevant and their meaning is a legal question. A surety should not give legal advice to a claimant on the bond. There is no special or fiduciary relationship between them, and a claimant should seek its own legal counsel.

Response to Comment: The commissioner has considered the comment and rejects it. The subsection does not require that legal advice be given. Moreover, impartiality is not inconsistent with fairness.

4. Summary of Comment: The changes to existing Sections 2695.4(a) and (b) would have an adverse impact on the ability of sureties to handle claims promptly and responsibly. A knowledge of construction or other subject matters of the underlying obligation is often more useful than a law degree in quickly and amicably resolving claims. The proposed regulation would have the unintended consequence of forcing the surety to involve lawyers from the beginning of the process even if there is no substantive dispute with the obligee or claimant.

Response to Comment: The Commissioner has considered this comment and rejects it. Sureties are charged with knowledge of the statutes and regulations to which they are subject and which may apply to the different classes of claims submitted to them. Sureties' knowledge of these matters is superior to that of the beneficiaries of bonds.

Comment No.: **23**
Section: **2695.4(a)**
Commentator: Carol LaPlant, Choate Law Firm
Date: May 9, 2002
Type of Comment: Written

Summary of Comment: The subsection is consistent with case law and explicitly clarifies that the prohibition on concealment encompasses active misrepresentation and passive failure to disclose information concerning the basis for settling the claim. The duty of full, accurate disclosure is likely to benefit consumers, for example, by resulting in more accurate total automobile loss valuations and/or in consumer awareness of how the valuation is determined.

Response to Comment: The commissioner has considered the comment and accepts it.

Comment No.: **29**
Section: **2695.4(a)**
Commentator: Steve McManus, State Farm Insurance Companies
Date May 9, 2002
Type of Comment: Written

Summary of Comment: It is not clear what obligations are imposed on an insurer by a regulation that directs that "no insurer shall misrepresent, conceal or fail to disclose" information. A prohibition of a non-act does not clearly direct an insurer as to the expected conduct, in contrast to the currently existing affirmative language. Moreover, eliminating the connection between the required disclosure (or prohibited nondisclosure) and the specific claim presented by the claimant makes the obligations of the insurer unclear.

Response to Comment: The commissioner has considered the comment and rejects it. First, the sentence is grammatically correct. Second, a prohibition against failing to disclose points to a norm of disclosure. Finally, the connection between the disclosure and the specific claim presented has not been eliminated; instead, it has been strengthened through a change to be made pursuant to Comment No. 17, from Douglas deVries, above.

Comment No.: **37**
Section: **2695.4(a)**
Commentator: Bennett L. Katz, Farmers Insurance Group
Date: May 14, 2002
Type of Comment: Written

Summary of Comment: The phrase "any insurance policy" is unclear and potentially includes policies that are not relevant to the subject claim. For clarity, the language should read "any applicable insurance policy . . ."

Response to Comment: The commissioner has considered the comment and rejects it. However, the subsection will be changed pursuant to Comment No. 17, from Douglas deVries, above.

Comments Re: SECTION 2695.4(a)(1)

Comment No.: **4**
Section: **2695.4(a)(1)**
Commentator: John Metz
Date: April 30, 2002
Type of Comment: Written

Summary of Comment: The phrase "upon receipt of additional proofs of claim" should be deleted. The preeminent issue is to assure the payment of all benefits to which such a claimant is entitled, not the need or lack thereof of a proof of claim. The insurer's cooperation and assistance will lead to the provision by the claimant of any requisite additional information.

Response to Comment: The commissioner has considered the comment and accepts it. Subsection 2695.4(a)(1) will be changed to read as follows:

> **(1) When additional benefits might reasonably be payable under an insured's policy ~~upon receipt of additional proofs of claim~~, the insurer shall immediately communicate this fact to the insured and cooperate with and assist the insured in determining the extent of the insurer's additional liability.**

Comment Nos.: **13, 29**
Section: **2695.4(a)(1)**
Commentator: G. Diane Colborn, Personal Insurance Federation
Date: May 7, 2002
Type of Comment: Written
Also commented by: Steve McManus, State Farm Insurance Companies
Date: May 9, 2002
Type of Comment: Written
Also commented by: Gary Hernandez, Sonnenschein, Nath & Rosenthal, Attorneys at Law
Date: May 8, 2002
Type of Comment: Oral - See Transcript in Rulemaking File

Summary of Comment: Insurance Code Section 790.03(h)(2) requires insurers to act "reasonably promptly" upon communications with respect to claims. Requiring "immediate" notification of the insured when additional benefits might be payable under a policy is unreasonable and inconsistent with other standards for reasonable timeliness in claims processing. The term "immediately" should be replaced with "as soon as reasonably practical" or "in a timely manner."

Response to Comment: The commissioner has considered the comment and rejects it. First, the "immediately communicate" language is the current law. Section 2695.4(a) has just been moved to Section 2695.4(a)(1). Second, the requirement of immediacy of action is neither unreasonable nor inconsistent with existing standards, as evidenced in the many sections of the regulations that have been in effect since 1993 and 1997.

For example, Section 2695.5(d) provides,

> Upon receiving notice of claim, every licensee or claims agent shall *immediately* transmit notice of claim to the insurer. (Italics added.)

Section 2695.5(b) (which appears in the section entitled "Duties upon Receipt of Communications) states,

> Upon receiving any communication from a claimant, regarding a claim, that reasonably suggests that a response is expected, every licensee shall *immediately*, but in no event more than fifteen (15) calendar days after receipt of that communication, furnish the claimant with a complete response based on the facts as then known by the licensee. (Italics added.)

Other sections that require immediacy of action are Sections 2695.5(e) and 2695.7(b) and (h).

Comment No.: **29**
Section: **2695.4(a)(1)**
Commentator: Steve McManus, State Farm Insurance Companies
Date: May 9, 2002
Type of Comment: Written

Summary of Comment: The requirement to "cooperate with and assist the insured in determining the extent of the insurer's additional liability" should be deleted. This phrase fails to accurately describe the claims process, as insureds do not determine the extent of liability. Insurers determine the extent of liability by applying the policy terms to the claim facts and explaining the process to the insured. When additional benefits may apply, the insurer should notify the first party claimant in a timely manner.

Response to Comment: The commissioner has considered the comment and rejects it. The insured's duty under the policy to provide "proof of loss" denotes a shared responsibility in determining the extent of liability. Moreover, the insurer's duty to consider its insured's interests at least as much as its own militates in favor of the insurer's cooperation with and assistance to its insured in this endeavor.

Comment No.: **37**
Section: **2695.4(a)(1)**
Commentator: Bennett L. Katz, Farmers Insurance Group
Date May 14, 2002
Type of Comment: Written

Summary of Comment: The phrase "When additional benefits might reasonably be payable . . ." is unclear, confusing and unnecessary, and provides an impossible standard for insurers to meet. The standard is extremely speculative. "When additional benefits are payable . . ." is an alternative approach that is more effective and less burdensome to affected persons.

Response to Comment: The commissioner has considered the comment and rejects it. Company adjusters who are adequately trained in the policy language and the law (as required by Section 2695.6, *inter alia*) should be capable of recognizing all benefits reasonably payable under a policy.

Comments Re: SECTION 2695.4(b)

Comment No.: **4**
Section: **2695.4(b)**
Commentator: John Metz
Date: April 30, 2002
Type of Comment: Written

Summary of Comment: The word "verified" should be added to this subsection as follows:

> **(b)** ~~(c)~~ No insurer shall deny a claim on the basis of the claimant's failure to exhibit property, unless there is **verified** documentation in the file (1) of demand by the insurer, and unfounded refusal by the claimant, to exhibit property, or (2) of the breach of any policy provision providing for the exhibition of property.

This addition is necessary to assure the truthfulness and accuracy of the information upon which claims processing and determinations are based. It is also consistent with the current duty of claimants. It will reduce the number of disputes and the amount of litigation. It will severely hamper the opportunity for misconduct by unscrupulous insurers. It will protect insureds and claimants, foster competition among honest insurers and limit the Department's regulatory burden by reducing the number of unfair claims acts or practices.

Response to Comment: The commissioner has considered the comment and rejects it, as it is outside the scope of the rulemaking. There has been no change to this subsection except as to its designation as (b) instead of (c).

Comments Re: SECTION 2695.4(d)(1)

Comment No.: **4**
Section: **2695.4(d)(1)**
Commentator: John Metz
Date: April 30, 2002
Type of Comment: Written

Summary of Comment: The second sentence of the subsection should be deleted as follows:

> (d) ~~(e)~~ No insurer shall:
>
> (1) request that a claimant sign a release that extends beyond the subject matter which gave rise to the claim payment unless, prior to execution of the release**,** the legal effect of the release is disclosed and fully explained by the insurer to the claimant in writing~~. For purposes of this subsection, an insurer shall not be required to provide the above explanation or disclosure to a claimant who is represented by an attorney at the time the release is presented for signature~~;

Regardless of whether a consumer is represented by counsel, these regulations are intended to promote fairness. The insurer and claimant (whether represented or not) may have different interpretations of the meaning and/or effect of the release. The parties should be encouraged to communicate rather than remain unaware of these potentially different views so as to avoid unnecessary litigation.

Response to Comment: The commissioner has considered the comment and rejects it, as it is outside the scope of the rulemaking. There has been no change to this subsection except as to its designation as (d) instead of (e) and the purely grammatical addition of a comma.

Comment No.: **17**
Section: **2695.4(d)(1)**
Commentator: Douglas K. deVries, Mart & deVries, Attorneys at Law
Date: May 8, 2002
Type of Comment: Written
Also commented by: Pete Kirkpatrick
Date: May 9, 2002
Type of Comment: Oral - See Transcript in Rulemaking File

Summary of Comment: This subsection should be changed as follows:

> **(d)** ~~(e)~~ No insurer shall:
>
> (1) request that a claimant sign a release that extends beyond the subject matter which gave rise to the claim payment ~~unless, prior to execution of the release, the legal effect of the release is disclosed and fully explained by the insurer to the claimant in writing~~. . . .

Insurers treat this subsection as relating not only to releases signed in conjunction with tendering payment of a claim but also as applying to any releases or authorizations they ask the insured to sign during processing of the claim. As such, insurers view the limitations of disclosure and full explanation of the document's legal effect as being satisfied through nothing more than a statement to the effect that it authorizes the insurer to obtain such materials and contact anyone with information about them.

This, in effect, creates a "carte blanche" for insurers to obtain releases that in fact do extend beyond the subject matter of the claim. For example, in an occupation disability benefit claim, insurers have asked for release of tax returns and other private information, or in a claim for disabling injuries from an auto accident, insurers have asked for release of psychiatric records, alcohol and drug records, private association affiliation records and other private information.

Response to Comment: The commissioner has considered the comment and rejects it, as it is outside the scope of the rulemaking. There has been no change to this subsection except as to its designation as (d) instead of (e) and the purely grammatical addition of a comma.

Moreover, Section 2695.7(d) as it exists and as it is proposed to be amended, clarifies that insurers cannot ask for information they do not need, as follows:

> (d) **Every insurer shall conduct and diligently pursue a thorough, fair and objective investigation and** ~~No insurer~~ shall **not** persist in seeking information not reasonably required for or material to the resolution of a claim dispute.

Comments Re: SECTION 2695.4(d)(2)

Comment No.: **4**
Section: **2695.4(d)(2)**
Commentator: John Metz
Date: April 30, 2002
Type of Comment: Written

Summary of Comment: The words "and payment of any undisputed portion of the claim is not made contingent upon the claimant's signing such a release" should be added to this subsection, and the second sentence deleted, as follows:

> (d) ~~(e)~~ No insurer shall: . . .
>
> (2) be precluded from including in any release a provision requiring the claimant to waive the provisions of California Civil Code Section 1542~~,~~ provided that, prior to execution of the release, the legal effect of the release is disclosed and fully explained by **the** insurer to the claimant in writing **and payment of any undisputed portion of the claim is not made contingent upon the claimant's signing such a release**. ~~For purposes of this subsection, an insurer shall not be required to provide the above explanation or disclosure to a claimant who is represented by an attorney at the time the release is presented for signature.~~

The addition is necessary to clarify that such a request cannot be used to delay or deny payment of an otherwise undisputed portion of a claim. The use of such tactics by unscrupulous insurers is commonly known. This practice is unfair, harms claimants, competitors and adds to the Department's workload. The deletion is necessary because, regardless of whether a consumer is represented by counsel, these regulations are intended to promote fairness. The insurer and claimant (whether represented or not) may have different interpretations of the meaning and/or effect of the release. The parties should be encouraged to communicate rather than remain unaware of these potentially different views so as to avoid unnecessary litigation.

Response to Comment: The commissioner has considered the comment and rejects it, as it is outside the scope of the rulemaking. There has been no change to this subsection except as to the purely grammatical deletion of a comma and addition of the word "the."

Comments Re: SECTION 2695.4(e)

Comment No.: **4**
Section: **2695.4(e)**
Commentator: John Metz
Date: April 30, 2002
Type of Comment: Written

Summary of Comment: The words "or drafts" should be deleted as follows:

> **(e)** ~~(f)~~ No insurer shall issue checks ~~or drafts~~ in partial settlement of a loss or claim that contain or are accompanied by language releasing . . .

This deletion is necessary to clarify that the use of "drafts" should be prohibited. Because of the generally longer time period required before payment on a draft is actually made by the issuing bank (during which time the insurer can earn additional interest on the money) and because the insurer retains the ability to stop payment until the funds actually leave the issuing bank, drafts allow the insurer to receive the benefit of settlement without having actually made payment.

Response to Comment: The commissioner has considered the comment and rejects it, as it is outside the scope of the rulemaking. There has been no change to this subsection except as to its designation as (e) instead of (f).

Comment Nos.: **19, 25**
Section: **2695.4(e)**
Commentator: Amy Bach, United Policyholders
Date: May 9, 2002
Type of Comment: Written
Also commented by: Norma Garcia, Consumers Union
Date: May 9, 2002
Type of Comment: Written

Summary of Comment: This subsection should be amended to provide that "no insurer shall require a claimant to sign a release to recover uncontested policy benefits." Sending an insured a release for payment of uncontested policy benefits is not necessary and generally results in the insured incurring attorney's fees to make sure the release can safely be signed.

Response to Comment: The commissioner has considered the comment and rejects it, as it is outside the scope of the rulemaking. There has been no change to this subsection except as to its designation as (e) instead of (f).

Comments Re: SECTION 2695.5(a)

Comment No.: **4**
Sections: **2695.5(a)**
Commentator: **John Metz**
Date of comment: **4/30/02**
Type of comment: **Written & Oral**

Summary of comment: Recommends several changes to this subsection.

Response to comment: The commissioner considered the comment and rejects it. The comment is outside the scope of the rulemaking.

Comments Re: SECTION 2695.5(b)

Comment No.: **4**
Section: **2695.5(b)**
Commentator: **John Metz**
Date of comment: **4/30/02**

Type of comment: **Written & Oral**

Summary of comment: Recommends several changes to this subsection.

Response to comment: The commissioner considered the comment and rejects it. The comment is outside the scope of the rulemaking.

Comments Re: SECTION 2695.5(c)

Comment No.: **9**
Section: **2695.5(c)**
Commentator: **Home Warranty Association, Stoel Rives LLP, Sean E. McCarthy**
Date of comment: **5/7/02**
Type of comment: **Written**

Summary of comment: This subsection is inapplicable to the home protection business. A service call may be requested by the contract holder, a spouse, attorney, realtor, tenant or family member. A requirement that a written designation be obtained serves to delay service. In home protection business, the telephone request suffices for service.

Response to comment: The commissioner considered the comment and rejects it. The comment is outside the scope of the rulemaking.

Comment No.: **4**
Section: **2695.5(c)**
Commentator: **John Metz**
Date of comment: **4/30/02**
Type of comment: **Written & Oral**

Summary of comment: Recommends several changes to this subsection.

Response to comment: The commissioner considered the comment and rejects it. The comment is outside the scope of the rulemaking.

Comments Re: SECTION 2695.5(e)

Comment No.: **9**
Section: **2695.5(e)**
Commentator: **Home Warranty Association**
Stoel Rives LLP
Sean E. McCarthy
Date of comment: **5/7/02**
Type of comment: **Written**

Summary of comment: The requirements of this subsection do not logically apply to home protection contracts. There are no claim forms, and a service person's visit to repair or assess

and order replacements parts necessarily occurs as soon as the service person is available to visit the contract holder's home. The service person is not an employee of the home protection company.

Response to comment: The commissioner considered the comment and rejects it. While there may be no claim forms required to process home protection claims, the time frames and obligations outlined in this subsection complement the obligations of the home protection company. The subsection does not require that claims forms be submitted to the home protection company in order to effect notice of claim. Notice of claim may be effected through a telephone call. However, once notice is received, the subsection simply requires the home protection company to acknowledge such notice, and "… provide the claimant with any "necessary" forms, instructions and "reasonable assistance"…begin any necessary investigation…"

Comment No.: **4**
Section: **2695.5(e)**
Commentator: **John Metz**
Date of comment: **4/30/02**
Type of comment: **Written & Oral**

Summary of comment: Recommends language should be changed to read as follows:

"Upon receiving notice of claim, every insurer shall…do the following unless the notice of claim received is a notice of legal action '**against the licensee, but only with respect to the claim at issue'."** This is necessary to avoid confusion and the loss of other paid for benefits by claimants. The licensee continues to owe all duties to a claimant under other provisions of the same policy or under other policies that it owed prior to receiving notice of legal action.

Response to comment: The commissioner considered the comment and rejects it. The exceptions in this subsection only apply to issues that are part of the legal action received by the company. Nothing in the subsection excuses the licensee from performing its obligations under the contract and under the law.

Comments Re: SECTION 2695.5(e)(1)

Comment No.: **19**
Section: **2695.5(e)(1)**
Commentator: : **United Policyholders, Amy Bach**
Date of comment: **5/8/02**
Type of comment: **Written**

Summary of comment: Subsection should be amended to require that insurers acknowledge receipt of a notice of a claim in writing to the claimant in addition to making the required notation in the claim file.

Response to comment: The commissioner considered the comment and rejects it. The comment is outside the scope of the rulemaking.

Comment No.: **4**

Section: **2695.5(e)(1)**
Commentator: **John Metz**
Date of comment: **4/30/02**
Type of comment: **Written & Oral**

Summary of comment: Recommends several changes in language.

Response to comment: The commissioner considered the comment and rejects it. The comment is outside the scope of the rulemaking.

Comments Re: SECTION 2695.5(e)(2)

Comment No.: **4**
Section: **2695.5(e)(2)**
Commentator: **John Metz**
Date of comment: **4/30/02**
Type of comment: **Written & Oral**

Summary of comment: Recommends several changes in language.

Response to comment: The commissioner considered the comment and rejects it. The comment is outside the scope of the rulemaking.

Comments Re: SECTION 2695.5(e)(3)

Comment No.: **4**
Section: **2695.5(e)(3)**
Commentator: **John Metz**
Date of comment: **4/30/02**
Type of comment: **Written & Oral**

Summary of comment: Recommends several changes in language.

Response to comment: The commissioner considered the comment and rejects it. The comment is outside the scope of the rulemaking.

Comments Re: SECTION 2695.6

Comment No.: **19**
Section: **2695.6**
Commentator: : **United Policyholders, Amy Bach**
Date of comment: **5/8/02**
Type of comment: **Written**

Summary of comment: Recommends extending the training and certification requirements in this section to insurance code 790.03(h).

Response to comment: The commissioner considered the comment and rejects it. The comment is outside the scope of the rulemaking.

Comment No.: **4**
Section: **2695.6**
Commentator: **John Metz**
Date of comment: **4/30/02**
Type of comment: **Written & Oral**

Summary of comment: Recommends addition of the language **"thorough"** in subsection 2695.6(a) and recommends the addition of **language "insurance code sections 790.03(h) and 790.06"** in several other parts of this subsection.

Response to comment: The commissioner considered the comment and rejects it. The comment is outside the scope of the rulemaking.

Comments Re: SECTION 2695.6(b)

Comment No.: **19**
Section: **2695.6(b)**
Commentator: **United Policyholders, Amy Bach**
Date of comment: **5/8/02**
Type of comment: **Written**

Summary of comment: Insurers frequently use attorneys to investigate claims, conduct examinations under oath, and negotiate claims settlements. These attorneys must be trained in the regulations.

Response to comment: The commissioner considered the comment and rejects it. The comment is outside the scope of the rulemaking.

Comments Re: SECTION 2695.7, generally

Comment No.: **7**
Section: **2695.7, generally**
Commentator: **Underwriters at Lloyd's**
LeBoeuf, Lanb, Greene, MacRae
Dean Hansell
Date of comment: **5/9/02**
Type of comment: **Written**

1. Summary of comment: Large commercial insureds should be exempt from these regulations for the following reasons:

- Large insureds are sophisticated and frequently managed by large brokerage houses and risk managers

- The nature of claims tend to be complex and deal with issues and litigation that may last for many years
- Large commercial insureds with minimal exposure in California would be subject to the regulations even though the majority of insureds are domiciled outside of the country
- Claims for large commercial insureds often involve multiple insurers covering the same loss (multiple policies – multiple insureds). Therefore, it is problematic for several insurers to individually comply with each and every regulation

Response to comment: The commissioner has considered the comment and rejects it. While it is true that large insureds may have more complex claims and also have the benefit of sophisticated representation, nothing contained in the proposed language requires excessive and unmanageable or burdensome obligations by insurers in the processing and settlement of claims. An insurer may achieve compliance through an adjuster who represents all or several insurers. There is no need for each insurer to send letters individually or attempt to handle the claim as separate entities.

2. Summary of comment: Commentator proposes new subsection 2695.7(u):

"Notwithstanding any of the above provisions, if a claim brought by a claimant involves more than one insurer (including a syndicate of Lloyd's underwriters) subscribing to the same risk under either multiple policies or a single policy, any insurer may designate in writing one or more representatives to act on its behalf in complying with the general notification provisions of this Section 2695.7, in whole or in part. The selected representative(s) must provide the claimant with notification of the designation setting for the name(s), address(es), and telephone number(s) of the designated representative(s) and on whose behalf the designated representative(s) is (are) acting.

Designated representatives are responsible for providing all of the required notifications set forth in the designation."

Response to comment: The commissioner has considered the comment and rejects it. Nothing in the proposed regulations prohibits multiple insurers from implementing the process described in the recommendation as a procedure.

Comments Re: SECTION 2695.7(a)

Comment No.: **4**
Section: **2695.7(a)**
Commentator: **John Metz**
Date of comment: **4/30/02**
Type of comment: **Written**

Summary of comments: This section should be amended to add **"overall financial condition"** as a prohibited criteria for discrimination.

Response to comment: The commissioner considered the comment and rejects it. The financial condition of a claimant should be irrelevant when processing most claims, however there are

instances wherein the financial condition may be a critical factor in determining motivation to commit fraud. To review the financial condition of a claimant is not discriminatory but rather a relevant and often necessary part of the claims investigation process. The regulations still require timely investigation, payment and processing of claims even in cases of suspected fraud.

Comment No.: **19**
Section: **2695.7(a)**
Commentator: **United Policyholders, Amy Bach: Joined by Norma Garcia of Consumer's Union**
Date of comment: **5/8/02 & 5/9/02 respectively**
Type of comment: **Written**

1. Summary of comment: Insurers treat represented and non-represented claimants differently, and represented claimants typically receive substantially larger settlements. Therefore, the following language should be added to the proposed subsection:

"insurers may not discriminate in their claims settlement practices based on the fact that the claimant has or has not retained counsel."

Response to comment: The commissioner considered the comment and rejects it. The proposed language recognizes the commonly protected classes identified by Federal and State statutes. Represented and unrepresented claimants are not classes protected under these statutes. To add such protection to these regulations is outside the intent of this subsection. In addition, nothing in the current or proposed regulations allows an insurer to practice discrimination against a represented claimant. Further, safeguards already exist to prohibit unfair claims practices (Insurance Code Section 790.03) and unreasonably low settlement offers in subsection 2695.7(g).

2. Summary of comment: Claims agents routinely attempt to discourage claimants from retaining a representative so that they can retain a negotiating advantage over the claimant. For this reason the following language should be added to this subsection:

"no insurer shall discourage a claimant from hiring a qualified public adjuster or attorney to represent them in securing a fair claim settlement."

Response to comment: The commissioner considered the comment and rejects it. The recommended modifications are substantive and would completely change the focus of this subsection which is outside the current scope of the regulations and therefore should be considered during the next phase of the review and modification process.

Comments Re: SECTION 2695.7(b)

Comment No.: **13**
Section: **2695.7(b)**
Commentator: **PIF, G. Diane Colborn**
Date of comment: **5/7/02**
Type of comment: **Written and Oral**

1. Summary of Comment: The new language added to this section is impractical and unnecessary particularly with regard to third party claims. For instance, when liability is favorable to the insured, and the insurer denies liability in whole, it would be unnecessary to gather the actual amount of the claim from the third party simply to comply with this regulation.

Response to Comment: The commissioner has considered the comment, accepts in it part and rejects it in part. While the commissioner agrees that the actual amount of a claim that is denied in its "entirety" need not be documented, claims that are accepted or denied in part should be properly documented. Therefore, the subsection should be modified to read:

> Upon receiving proof of claim, every insurer, except as specified in subsection 2695.7(b)(4) below, shall immediately, but in no event more than forty (40) calendar days later, accept or deny the claim, in whole or in part. **The amounts accepted or denied shall be clearly documented in the claims file, <u>unless the claim has been denied in its entirety.</u>**

2. Summary of Comment: It is unclear as to what is meant by "amounts accepted or denied." This lack of clarity, particularly in third party cases, may cause claimants' attorneys to argue that the documented offer is the "amount accepted" and that must be paid even though the claim is not actually settled. Lack of payment could lead to bad faith lawsuits.

Response to Comment: The commissioner has considered the comment and rejects it. The commentator's concerns are unwarranted. The language is clear; nothing in this section requires payment by the insurer. The insurer is protected by the language of Section 2695.7(h) from having to pay amounts accepted by the insurer unless the third party claimant signs a release.

As to the commissioner's authority to promulgate the proposed language, Insurance Code Section 790.03(h)(3) requires the insurer to implement reasonable standards for the processing of claims. This necessarily includes adequate documentation of claim files. Furthermore, the commissioner is authorized under Insurance Code Section 733 to examine insurer claim files and his examiners must be able to discern what has occurred in a claim.

<u>Comment No.</u>: 4
Section: 2695.7(b)
Commentator: John Metz
Date of comment: 4/30/02
Type of comment: Written

Summary of comment: The following should be added to the regulation, "The amounts **<u>or other benefits</u>** accepted or denied…." to clarify that there are other benefits due claimants under an insurance policy separate from payments. Commentator references California Penal Code 550 (b)(1) – (3).

Excerpt from penal code follows:

550. (b) It is unlawful to do, or to knowingly assist or conspire with any person to do, any of the following:

(1) Present or cause to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.
(2) Prepare or make any written or oral statement that is intended to be presented to any insurer or any insurance claimant in connection with, or in support of or opposition to, any claim or payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.
(3) Conceal, or knowingly fail to disclose the occurrence of, an event that affects any person's initial or continued right or entitlement to any insurance benefit or payment, or the amount of any benefit or payment to which the person is entitled.

Response to comment: The commissioner has considered the comment and rejects it. The regulation applies to proof of claim, as defined, which does not preclude other benefits claimed, accepted or denied. Benefits which are absorbed by the insurance company as a part of the claims process such as defense costs and claims handling expenses are not subject to this regulation.

Comment No.: **18**
Section: **2695.7(b)**
Commentator: **National Association of Independent Insurers, Sam Sorich**
Date of comment: **5/8/02**
Type of comment: **Written**

Summary of comment: The amendments are too broad. An insurer would need to document amounts denied whenever a claim is denied. This is unreasonable when applied to instances where a claim is totally denied because of lack of coverage.

Response to comment: The commissioner considered the comment and accepts it. See response to PIF.

Comment No.: **28**
Section: **2695.7(b)**
Commentator: **CSAA, Douglas A. Lutgen**
Date of comment: **5/8/02**
Type of comment: **Written**

Summary of comment: This language materially and unnecessarily adds substantial file handling requirements in cases where there is no liability under the policy.

Response to comment: The commissioner considered the comment and accepts it. See response to PIF.

Comment No.: **35**
Section: **2695.7(b)**
Commentator: **21st Century Insurance Company, via Barger & Wolen LLP, Kent R. Keller**
Date of comment: **5/7/02**
Type of comment: **Written & Oral**

1. Summary of comment: This amendment is unnecessary because it requires insurers to calculate damages even where liability is denied.

Response to comment: The commissioner considered the comment and accepts it. Language will be added to the proposed regulations stating that no documentation will be required when the claim is denied in its entirety. Refer to response to PIF.

2. **Summary of comment:** The language is unclear in that "clearly documented" can be subject to various interpretations. The language should be amended to read:

"Where damages are accepted or denied in whole or in part, any applicable amounts accepted or denied shall be documented in the claim file."

Response to comment: The commissioner considered the comment and rejects it. The proposed language simply requires that amounts accepted or denied be clearly documented in the claim file. The recommended change is unwarranted. Eliminating the term "clearly", as recommended, does not further the intent of this subsection.

3. **Summary of comment:** The language is also duplicative of the basic standard for documentation of files set forth in Section 2695.3.

Response to comment: The commissioner considered the comment and rejects. The proposed language requires specific documentation of amounts accepted or denied which is consistent with and complements Subsection 2695.3.

Comment No.: 29
Section: 2695.7(b)
Commentator: State Farm Insurance Companies, Steve McManus
Date of comment: 5/9/02
Type of comment: Written

Summary of comment: The new language is problematic because insurers do not typically estimate the amount of damages on claims denied based on lack of coverage under the policy or lack of legal liability.

Response to comment: The commissioner considered the comment and accepts it. The language will be amended. See response to PIF.

Comment No.: 16
Section: 2695.7(b)
Commentator: Developers Surety and Indemnity Company (Notation)
Robins, Kaplan, Miller & Ciresi LLP, David C. Veis
Date of comment: 5/8/02
Type of comment: Written

Summary of comment: The reduced time frames in this subsection are unfair and inconsistent with legislative rules and court decisions accepting the unique aspects of the tripartite suretyship relationship and the difficulty of ascertaining the proper resolution of a dispute.

Response to comment: The commissioner considered the comment and rejects it. Although the tripartite relationship that exists in connection with a surety bond is unique, statutory and case law does not preclude the application of these regulations to surety claims. The proposed amendment is necessary because the minimum standards for settling claims are as applicable to surety as to other types of claims. These minimum standards work to protect the claimant regardless of the complexity of the claim. Further, the commentator is reminded that the surety may also avail itself of the extension of time provided by Subsection 2695.7(c)(1).

Comment No.: **11**
Section: **2695.7(b)**
Commentator: **Association of California Insurance Companies, Jeffrey J. Fuller**
Date of comment: **5/7/02**
Type of comment: **Written**

Summary of comment: The comment is presented in its entirety.

"This section should apply only to claims that are covered under a policy issued by the insurer to the claimant."

Response to comment: The commissioner considered the comment and rejects it. The comment is unclear as to its intent. However, if the commentator suggests by this comment that this subsection should apply only to first party claims, and not to third party liability claims, this suggestion is without merit. The Unfair Practices Act and the great majority of these claims regulations are intended to apply to both first and third party claims.

Comment No.: **9**
Section: **2695.7(b)**
Commentator: **Home Warranty Association**
Stoel Rives LLP
Sean E. McCarthy
Date of comment: **5/7/02**
Type of comment: **Written**

Summary of comment: Application of this section to home protection contracts is unclear and inconsistent with the nature of the business. No "proof of claim" is required from the contract holder. Upon contacting the home protection company with a service request, assistance is dispatched to the contract holder in the form of a repair or replacement. Proof of claim does not trigger the service.

Response to comment: The commissioner considered the comment and rejects it. The commentator is referred to Section 2695.2(s) – proof of claim means "…**any evidence** or documentation…" When the home protection company inspects the item in need of repair, proof of claim requirements under the proposed language have been met. From that point, the home protection company may accept or deny the claim as required by the regulations. Further, see response to Section 2695.1(d).

Comment No.: **26**
Section: **2695.7(b)**

Commentator: **Safeco, Ruben Cruz**
Date of comment: **5/9/02**
Type of comment: **Written**

Summary of comment: The comments are similar to PIF.

Response to comment: The commissioner considered the comment and accepts it in part and rejects it in part. See response to PIF.

Comments Re: SECTION 2695.7(b)(1)

Comment No.: **13**
Section: **2695.7(b)(1)**
Commentator: **PIF, G. Diane Colborn**
Date of comment: **5/7/02**
Type of comment: **Written**

Summary of Comment: The proposed language relating to disclosure of "statutes" exceeds the commissioner's authority and requires that companies provide legal analysis in addition to an explanation of the statute.

Response to Comment: The commissioner has considered the comment and rejects it. The proposed language merely requires that the company relate to the claimant the statutes and laws used by the insurer to deny a first party claim or claim under a surety bond. Specifically, Section 790.03(h)(13) provides that it is an unfair claims practice for an insurer "to fail to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law . . ." (Emphasis added.) The proposed language adds clarity.

Comment No.: **4**
Section: **2695.7(b)(1)**
Commentator: **John Metz**
Date of comment: **4/30/02**
Type of comment: **Written**

1. Summary of comment: Where the proposed language reads "denied" or where it reads "rejection or denial" commentator recommends addition of the terms "**accepts** or **acceptance"** respectively. The addition is necessary to provide clarity for claimants and insurers regarding the bases for all coverage decisions, to avoid improper payment of claims, as well as improper denials. It will help eliminate situations in which claimants are left uncertain about whether their claims were paid in error or because the insurer was doing them a favor as opposed to a legal duty to pay. It will also help eliminate situations in which the insurer improperly pays benefits to the detriment of other policies holders i.e. increase insurance premiums.

Response to comment: The commissioner considered the comment and rejects it. This regulation was specifically designed to address denial or rejection of claims in whole or in part. Requiring an insurer to provide written explanation for every acceptance of a claim would be burdensome and unnecessary. Payment amounts that are less than proof of claim require full explanation. Payments that match proof of claim require no further explanation. However,

nothing in the regulations precludes an insurer from providing written explanation of amounts accepted if the insurer believes it is necessary. Additionally, if a claimant requests an explanation of any part of the claims process, 2695.5 (b) requires that an insurer respond in writing.

2. Summary of comment: Commentator recommends adding the term **"regulation"** after the word "statute" in the proposed language to clarify all bases upon which the insurer relied in making its claims determination. This addition will eliminate needless litigation and foster the growth of a respected and trusted insurance industry by weeding out the bad players.

Response to comment: The commissioner has considered the comment and accepts it. The following language is recommended:

(1)…Where an insurer's denial of a first party claim or claim under a surety bond in whole or in part, is based on a specific statute, **regulation,** or specific bond or policy provision, condition or exclusion, the written denial shall include reference thereto and provide an explanation of the application of the statute, **regulation,** provision, condition or exclusion to the claim. Every insurer that denies or rejects a third party claim, in whole or in part, or disputes liability or damages shall do so in writing.

3. Summary of comment: To protect third party claimants, the following words should be added to the end of the subsection:

"…and shall include reference to any fact, specific statute, regulation, or specific bond or policy provision, condition or exclusion upon which it bases any such denial, rejection or acceptance, and provide an explanation of the application of the statute, regulation, provision, condition or exclusion to the claim.

Response to comment: The commissioner has considered the comment and rejects it. Please refer to response to Summary of Comment No. 1 from this same commentator as respects adding the word "acceptance" to the proposed regulations.

Further, the recommended modifications are substantive and would completely change the focus of the insurer's responsibility to a third party claimant which is outside the current scope of the regulations and therefore should be considered during the next phase of the review and modification process.

Comment No.: 8
Section: 2695.7(b)(1)
Commentator: California Surety Federation, Paul Gladfelty
Date of comment: 5/6/02
Type of comment: Written and Oral

Summary of comment: The proposed language forces the surety to practice law on behalf of the claimant without regard for the obligation the surety also has to the principal. The surety's obligation is strictly construed so as not to impose a burden not contained in or clearly inferable from language of the contract. It s a practical impossibility for a surety to comply with this provision without making legal judgments as well as factual determinations regarding the actions of both the principal and the claimant.

Response to comment: The commissioner considered the comment and rejects it. The proposed language does not require an insurer to practice law on behalf of the claimant. The language simply requires disclosure of the statutes and laws relied upon by the insurer to deny a claim. The language does not interfere with the surety's responsibility to its principal. A surety may continue to strictly construe its obligations to a beneficiary under a contract bond which is not in conflict with its separate obligation to disclose statutes and laws relied upon to deny a claim.

Comment No.: **35**
Section: **2695.7(b)(1)**
Commentator: **21st Century Insurance Company, Barger & Wolen LLP, Kent R. Keller**
Dateof comment: **5/7/02**
Type of comment: **Written**

Summary of comment: The proposed language would inappropriately require insurers to make legal interpretations of statutes and may improperly require the disclosure of privileged legal reasoning.

Response to comment: The commissioner considered the comment and rejects it. Nothing in the proposed language requires disclosure of privileged legal reasoning. Further, see response to PIF.

Comment No.: **29**
Section: **2695.7(b)(1)**
Commentator: **State Farm Insurance Companies, Steve McManus**
Date of comment: **5/9/02**
Type of comment: **Written**

1. Summary of comment: The amendment is unnecessary because claim denials are based on language in the policy contract, not on statutory law.

Response to comment: The commissioner considered the comment and rejects it. Many claims are denied based on statutory law alone – example: expiration of statute of limitations.

2. Summary of comment: Amendment requiring claims personnel to explain statutory law puts them in the position of rendering legal opinions and, possibly, unauthorized practicing of law.

Response to comment: The commissioner considered the comment and rejects it. See response to PIF.

3. Summary of comment: Commentator refers to comments made to 2695.1(c) as a basis to delete surety from this subsection. Surety should be deleted because the surety's primary obligation is always to the principal. The surety's obligation to perform is secondary and requires proof of default by the principal before the obligation even begins to exist. This process and the proof required of the obligee can become lengthy and very detailed. Surety claims are complex and the timeframes in 2695.7 are highly impractical and commercially unreasonable.

Response to comment: The commissioner considered the comment and rejects it. The commissioner recognizes the surety's obligations to both the principal and the obligee. Nothing contained in the proposed language interferes with the surety's responsibilities in this tripartite relationship. As the surety is in a superior position as to knowledge of applicable statutes as respects denial of claims, the proposed language simply requires the surety to explain the application of a statutes that are used as a basis for denial. Further, there are no timeframes required in this subsection.

Comments Re: SECTION 2695.7(b)(3)

Comment No.: **13**
Section: **2695.7(b)(3)**
Commentator: **PIF, G. Diane Colborn**
Date of comment: **5/7/02**
Type of comment: **Written**

Summary of Comment: The meaning of partial denial is unclear.

Response to Comment: The commissioner has considered the comment and rejects it. The proposed language, "Upon acceptance of the claim **in whole or in part** . . .," is not ambiguous. This section simply requires the insurer to notify the claimant that, if the claimant believes that all or part of the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the department.

Comment No.: **4**
Section: **2695.7(b)(3)**
Commentator: **John Metz**
Date of comment: **4/30/02**
Type of comment: **Written**

Summary of comment: To assure that claimants are informed of all avenues of redress that are open to them, the following language should be added to this subsection:

"Written notification pursuant to this subsection shall include a statement that, if the claimant believes **all or part** of the claim has been wrongfully denied or rejected, he or she may, **'in addition to pursuing any other avenue of redress permitted by law,'** have the matter reviewed…".

Response to comment: The commissioner has considered the comment and rejects it. The proposed language does not preclude a claimant from pursing other avenues of redress and invites them to contact the Department at which point such avenues would be explained. This is the intent of this subsection.

Comment No.: **35**
Section: **2695.7(b)(3)**
Commentator: **21st Century Insurance Company, Barger & Wolen LLP, Kent R. Keller**
Date of comment: **5/7/02**
Type of comment: **Written**

Summary of comment: The proposed language is unclear because it could require notice in cases of disputed facts, as opposed to denials citing particular policy provisions. The regulation should make the notice requirement inapplicable to disputes over liability and settlement value.

Response to comment: The commissioner considered the comment and rejects it. This subsection has never applied to cases in which denials are based on specific policy language. This subsection requires insurers to notify all claimants that they may contact the Department if they believe their claim has been wrongfully denied. The proposed language only clarifies that this requirement applies to claims that have been denied in whole or in part.

Comment No.: **26**
Section: **2695.7(b)(3)**
Commentator: **Safeco, Ruben Cruz**
Date of comment: **5/9/02**
Type of comment: **Written**

Summary of comment: Comments are similar to PIF, Comment 13, above.

Response to comment: The commissioner considered the comment and rejects it. See response to PIF, above.

Comments Re: SECTION 2695.7(b)(5)

Comment No.: **13**
Section: **2695.7(b)(5)**
Commentator: **PIF, G. Diane Colborn**
Date of comment: **5/7/02**
Type of comment: **Written and Oral**

1. Summary of Comment: The proposed language lacks statutory authority, fails to meet consistency and necessity standards, and has the effect of changing policy language. The commentator is not aware of any case that decided the cost of labor is not subject to depreciation.

Response to Comment: The commissioner has considered the comment and rejects it. This proposal does not have the effect of changing policy language. The commissioner is not aware of any policy provisions that permit the depreciation of labor. No evidence has been provided that policy language allows for such depreciation. A reasonable interpretation of a fair settlement under Section 790.03(h) includes the full value of labor.

2. Summary of Comment: Labor is an integral part of manufactured household items and cannot be separated from the total value.

Response to Comment: The commissioner has considered the comment and rejects it. The comment fails to distinguish between labor used to manufacture a product and labor used to repair or replace an already manufactured item. The labor to manufacture an item is not within the scope of this regulation. The labor used to repair or replace an already manufactured item is

separately calculated and delineated in an estimate for repair or replacement. Furthermore, depreciation should not be applied to labor because labor is not subject to wear and tear.

3. Summary to Comment: The requirement to itemize all adjustments will be burdensome, time consuming for insurers, unnecessary in many instances, and impractical as applied to individual personal contents losses under a fire policy.

Response to Comment: The commissioner has considered the comment and rejects it. The proposed language, while modified to add clarity, has been moved from the current auto section of the regulations, specifically section 2695.8(b)(1)(C), to apply to all lines of insurance. The commissioner believes that the same standard of disclosure should apply to all lines of insurance that are subject to the regulations.

Comment No.: 4
Section: 2695.7(b)(5)
Commentator: John Metz
Date of comment: 4/30/02
Type of comment: Written

Summary of comment: In order to assure truthfulness and accuracy of the information upon which claims processing and determinations are based, the following additional language is recommended:

"When the amount claimed is adjusted because of better, depreciation, or salvage, all justification for the adjustment shall be contained in the claim file **'and must be based on verified information'.** Any adjustments shall be discernable, measurable, itemized, and specified as to dollar amount, and shall accurately reflect the value of the betterment, depreciation, or salvage. The cost of labor is not subject to depreciation **'must be based on verified information'**".

Response to comment: The commissioner considered the comment and rejects it. The recommended language is unnecessary and redundant. The proposed language already requires adjustments to "accurately" reflect the value of adjustments.

Comment No.: 18
Section: 2695.7(b)(5)
Commentator: Samuel Sorich, National Association of Independent Insurers
Date of comment: 5/8/02
Type of comment: Written

1. Summary of comment: The proposed language is unfair, expensive and unauthorized. The cost of labor is intrinsic to the value of any repair. Depreciation logically applies to the entire repair job which includes labor. Prohibiting such practice will increase the cost of insurance.

Response to comment: The commissioner considered the comment and rejects it. The comment fails to distinguish between labor used to manufacture a product and labor used to repair or replace a manufactured item. The labor to manufacture an item is not within the scope of this regulation. The labor used to repair or replace an already manufactured item is separately

calculated and delineated in an estimate for repair or replacement. Furthermore, depreciation should not be applied because labor is not subject to wear and tear.

2. **Summary of comment:** CDI has no authority to prohibit policy provisions which permit the depreciation of the cost of labor. Such authority resides in the legislature, not in a regulatory agency.

Response to comment: The commissioner considered the comment and rejects it. A reasonable interpretation of a fair settlement under Section 790.03(h) includes the full value of labor.

3. **Summary of comment:** Adding the word "fully" adds nothing but uncertainty and would make an insurer's good faith explanation subject to being second guessed by examiners or attorneys who feel the explanation is not full enough. Recommends deletion of the word "fully".

Response to comment: The commissioner considered the comment and rejects it. A claimant is entitled to a full explanation of adjustments. To require an insurer to provide a full explanation is reasonable.

4. Summary of comment: Unit cost is a well accepted method for estimating property damage. The unit cost incorporates all items into one price estimate. The prohibition against depreciating labor costs would require the construction and insurance industries to change to a line item approach which breaks down each individual item going into the cost of repair. System changes would have to be implemented to use the line item approach and the costs would ultimately be passed on to consumers.

Response to comment: The commissioner has considered the comment and rejects it. The comment fails to distinguish between manufactured items and items that are repaired. The cost of labor for manufactured items is not within the scope of this regulation. However, the cost of labor to repair or replace items does fall within the scope of this subsection and a reasonable interpretation of a fair settlement under Section 790.03(h) includes the full value of labor. The line item approach to claim adjusting identifies and itemizes the labor, parts, and materials required to repair or replace damaged property. The unit cost method does not itemize and separately identify the costs of labor, parts, and materials. Since labor is not subject to depreciation the line item approach (which breaks-out labor, parts, and materials) is the only reasonable approach. Further, requiring construction cost guides and computer programs to change to the line item approach is not overly burdensome on insurers or their vendors.

Comment No.: **35**
Section: **2695.7(b)(5)**
Commentator: **21st Century Insurance Company**
Barger & Wolen LLP
Kent R. Keller
Date of comment: **5/7/02**
Type of comment: **Written**

1. Summary of comment: This amendment is an improper attempt to regulate policy language and is inconsistent with established authority governing depreciation.

Response to comment: The commissioner considered the comment and rejects it. This proposal does not have the effect of changing policy language. The commissioner is not aware of any policy provisions that permit the depreciation of labor. No evidence has been provided that policy language allows for such depreciation. A reasonable interpretation of a fair settlement under Section 790.03(h) includes the full value of labor. (See response to PIF)

2. **Summary of comment:** In third party claims, the amendment would make insurers liable for more than what claimants are entitled to collect and would substantially increase insurance costs. Currently third party claimants are only entitled to actual cash value of damaged property.

Response to comment: The commissioner considered the comment and rejects it. The commentator makes no distinction between a manufactured item and the cost to repair damaged property. A third party claimant is entitled to a fair settlement. A manufactured item, and the inclusive labor costs of such item, may be subject to depreciation. However, the labor that is associated with a line item repair cost is not subject to depreciation. Fair settlements in keeping with this subsection would not result in third party claimants being over-indemnified. A reasonable interpretation of a fair settlement under Section 790.03(h) includes the full value of labor.

3. **Summary of comment:** Case law supports IRS tax codes which allow for the depreciation of labor.

Response to comment: The commissioner considered the comment and rejects it. The commentator is confusing depreciation as defined by tax codes and depreciation as used in the adjustment of insurance claims and its application to fair claims settlement practices.

Comment No.: **29**
Section: **2695.7(b)(5)**
Commentator: **State Farm Insurance Companies, Steve McManus**
Date of comment: **5/9/02**
Type of comment: **Written**

Summary of comment: Objects to proposed language that reads "the cost of labor is not subject to depreciation" because it is not statutorily authorized and is not necessary. CDI should not expect an insurer to separate the cost of labor from the cost of materials and overhead in adjusting a property claim.

Response to comment: The commissioner considered the comment and rejects it**.** See response to PIF.

Comment No.: **11**
Section: **2695.7(b)(5)**
Commentator: **Association of California Insurance Companies, Jeffrey J. Fuller**
Date of comment: **5/7/02**
Type of comment: **Written**

Summary of comment: The comments are similar to NAII.

Response to comment: The commissioner considered the comment and rejects it. See response to NAII.

Comment No.: **26**
Section: **2695.7(b)(5)**
Commentator: **Safeco, Ruben Cruz**
Date of comment: **5/9/02**
Type of comment: **Written**

Summary of comment: Comment is similar to PIF.

Response to comment: The commissioner considered the comment and rejects it. See response to PIF.

Comment No.: **Oral - See Transcript in Rulemaking File**
Section: **2695.7(b)(5)**
Commentator: **Sonnenschein, Nath and Rosenthal, Gary Hernandez**
Date of comment: **5/8/02**
Type of comment: **Oral - See Transcript in Rulemaking File**

Summary of Comment: Proposed language interprets policy language, attempting to define what is meant by depreciation in settling claims. The commissioner is not authorized to promulgate regulation of terms used in policies.

Response to Comment: The commissioner has considered the comment and rejects it. See response to PIF.

Comment No.: **Oral - See Transcript in Rulemaking File**
Section: **2695.7(b)(5)**
Commentator: **Safeco, Michael Burton**
Date of comment: **5/9/02**
Type of comment: **Oral - See Transcript in Rulemaking File**

Summary of comment: Comment is similar to PIF.

Response to comment: The commissioner considered the comment and rejects it. See response to PIF.

Comments Re: SECTION 2695.7(c)

Comment No.: **4**
Section: **2695.7(c)**
Commentator: **John Metz**
Date of comment: **4/30/02**
Type of comment: **Written**

Summary of comment: In order to clarify the insurer's duty to fully inform the claimant of all reasons known to the insurer as to why it needs additional time to accept or deny a claim, the following additional language is recommended:

"…This written notice shall specify any additional information the insurer requires in order to make a determination and state **'and all'** continuing reasons for the insurer's inability to make a determination."

Response to comment: The commissioner considered the comment and rejects it. As written, the proposed regulation already requires the insurer to advise the claimant of "any" continuing reasons as to why the claim cannot be accepted or denied. Further, the proposed language in 2695.7(d) and its underlying statute CIC 790.03(h)(3) requires an insurer to perform thorough, diligent, fair and objective investigation and not persist in seeking information not reasonably required. The recommended language is not necessary. Also, the recommendation is outside the scope of the rulemaking.

Comments Re: SECTION 2695.7(d)

Comment No.: **17**
Section: **2695.7(d)**
Commentator: **Mart & deVries – Attorneys at Law, Douglas K. deVries**
Date of Comment: **5/8/02**
Type of Comment: **Written**

Summary of Comment: While the Department's effort to expand 2695.7 (d) to require a diligent investigation is understood and agreed with, it is likely that insurers will abuse the intent of the language and use it to delay, harass and over burden claimants with repetitive requests for the insured to obtain information at the insured's expense. Commentator believes this problem exists particularly with group disability coverage.

Commentator suggests that new language be added to 2695.7(d) as follows:

"No notice provision or request to the insured relieves an insurer of its obligation to conduct and diligently pursue a thorough, fair and objective investigation, which is a non-delegable duty that may not be imposed on an insured, such as by requiring the insured to acquire and provide information not already in the insured's possession".

Response to Comment: The commissioner has considered the comment and rejects it. The proposed language in 2695.7 (d) does not give license to an insurer to delay, harass, or seek unnecessary information from a claimant or an insured, whether or not it involves an expense to the insured. Specifically, the language forbids an insurer from seeking information not reasonably required or material to the resolution of a claim. The commissioner believes that the proposed language sufficiently addresses the commentator's concerns.

Comment No.: **23**
Section: **2695.7(d)**
Commentator: **Carol P. LaPlant, ESQ.**
Date of Comment: **5/9/02**
Type of Comment: **Written**

Summary of Comment: The proposed language is appropriate because it would help prevent an insurer from using vendor total loss evaluations that are not representative of current retail prices of comparable vehicles in the local market.

Response to Comment: The commissioner has considered the comment and agrees. No change in proposed language is recommended.

Comment No.: **7**
Section: **2695.7(d)**
Commentator: **Underwriters at Lloyd's, LeBoeuf, Lamb, Greene, & MacRae, Dean Hansell**
Date of comment: **5/6/02**
Type of comment: **Written**

1. **Summary of Comment:** The standard outlined in the proposed language creates a substantial burden on insurers concerning investigation. An insurer will not be able to rely on the information provided by the insured. The proposed language shifts the burden from the insured to provide information to establish a claim to the insurer to affirmatively eliminate and/or substantiate the lack of a claim. This could lead to instances of deliberate non-disclosure by a claimant.

Response to comment: The commissioner has considered the comment and rejects it. The new language is consistent with, and adds clarity to, CIC section 790.03(h)(3) which requires prompt investigation and is consistent with the duty to provide reasonable assistance as prescribed in Subsection 2695.5(e)(2). The regulation intends to require an affirmative responsibility by the insurer to perform a diligent investigation. The law is clear that a minimum standard for a claim investigation is "thorough, fair and objective". See authority cited in Subsection 2695.7. Further, nothing prohibits an insurer from requesting information from its insured and relying on that information as a part of the investigation process. Additionally, the commissioner sees no correlation between the proposed language and deliberate non-disclosure by a claimant.

2. **Summary of Comment:** In commercial policies this requirement may run directly counter to the arrangements expressly contracted for between the policyholder and the commercial insured.

Response to comment: The commissioner has considered the comment and rejects it. The comment is confusing and ambiguous.

3. Summary of comment: The proposed language is vague and provides no guidance as to what conduct shall be sufficient to "diligently pursue a thorough, fair and objective investigation."

Response to comment: The commissioner has considered the comment and rejects it. The proposed language intends to more clearly prescribe the insurer's responsibility to investigate a claim without dictating or enumerating each and every step or method used to perform the requisite investigation. Investigation needs will vary on a case by case basis.

4. Summary of comment: Compliance will dramatically increase costs and slow down the processing of a claim because the insurer might need to conduct an independent investigation of each claim.

Response to comment: The commissioner has considered the comment and rejects it. The language of the regulation only expresses that which an insurer should have been doing all along. There should be no increased costs or delay in the processing of claims associated with this regulation.

Comment No.: 4
Section: 2695.7(d)
Commentator: John Metz
Date of comment: 4/30/02
Type of comment: Written and Oral

1. Summary of comment: It is the insurer's, not the claimant's, responsibility to conduct a sufficiently thorough investigation to establish the full fact, nature, extent and value of all covered loss, damage and liability. An example of a failure to conduct such investigations is evident in the absence of proper investigation after the Loma Prieta, and other, earthquakes in California. Investigations performed did not unearth hidden damage in multiple cases which caused enormous harm to insureds. Additionally, harm caused by lack of such investigation is also evident in vehicle total losses. For this reason, the following language should be added to the proposed regulation:

"d. Every insurer shall conduct and diligently pursue a thorough, fair and objective investigation **'sufficient to establish the full fact, nature, extent and value of all covered loss, damage and liability'** and shall not persist in seeking information not reasonable required for or material to the resolution of a claim dispute."

Response to comment: The commissioner considered the comment and rejects it. The language of the regulation in addition to the underlying statute 790.03(h)(3) is sufficient to address the concerns of the commentator.

2. Summary of comment: In the absence of modifying Section 2695.2 of the regulations to expand the terms "knowledge" or "know" to include "actual, implied, or constructive knowledge, including, but not limited to, that which is implied by operation of law", the following should be added to the end of the subsection:

"The insurer shall be charged with constructive notice of facts that it should have learned had it pursued the requisite investigation."

Response to comment: The commissioner considered the comment and rejects it. The language of the proposed regulations, existing statutes and case law is sufficient to address the concerns of the commentator.

Comment No.: 38
Section: 2695.7(d)
Commentator: American Insurance Association, Bill Gausewitz
Date of comment: 5/9/02

Type of comment: Written

Summary of comment: The proposed language lacks clarity and provides no guidance as to what conduct shall be sufficient to "diligently pursue a thorough, fair and objective investigation."

Response to comment: The commissioner has considered the comment and rejects it. The proposed language intends to more clearly prescribe the insurer's responsibility to investigate a claim without dictating or enumerating each and every step or method used to perform the requisite investigation. Investigation needs will vary on a case by case basis.

Comment No.: 18
Section: 2695.7(d)
Commentator: National Association of Independent Insurers, Sam Sorich
Date of comment: 5/8/02
Type of comment: Written and Oral

1. Summary of comment: The proposed amendments are unclear and unauthorized. These terms are not easily understood by insurers and should be rejected because of their lack of clarity or the terms should be defined.

Response to comment: The commissioner has considered the comment and rejects it. The proposed language intends to more clearly prescribe the insurer's responsibility to investigate a claim without dictating or enumerating each and every step or method used to perform the requisite investigation. Investigation needs will vary on a case by case basis.

2. Summary of comment: The three cases cited by the Department as authority involve an insurers' obligation to conduct fair investigations of claims but none of the cases uses or discusses the terms "diligent" "thorough" or "objective". The Department has no apparent authority to impose these undefined standards.

Response to Comment: The commissioner considered the comment and rejects it. The requirement "to **conduct and diligently pursue a thorough, fair and objective investigation**" is not a new standard nor is it unclear. It is authorized by case law, specifically *Egan v. Mutual of Omaha* (1979) 24 Cal.3d 809, as cited in the "Note" section below. While the opinion expressly employs only the term "thorough," the "diligent," "fair" and "objective" standards are consistent with the implied covenant of good faith and fair dealing. The Egan Court found that covenant to require "each contracting party to refrain from doing anything to injure the right of the other to receive the benefits of the agreement" *(Id.*, at p. 818), that "the insurer, when determining whether to settle a claim, must give at least as much consideration to the welfare of its insured as it gives to its own interests" (*Id.*), and that "an insurer fully inquire into possible bases that might support the insured's claim" (*Id.*, at p. 819).

These well-settled legal tenets, together with the statutory requirement of "prompt investigation" (Cal.Ins.Code, sec.790.03(h)(3)), authorize the language in Section 2695.7(d).

Comment No.: 37
Section: 2695.7(d)

Commentator: **Farmers Insurance Group, Bennett L. Katz**
Date of Comment: **5/14/02**
Type of Comment: **Written**

Summary of comment: "The added verbiage makes the entire section ambiguous. The sections should be adopted or removed."

Response to comment: The commissioner considered the comment and rejects it. The new language is consistent with, and adds clarity to, CIC Section 790.03(h)(3) which requires prompt investigation. Further the proposed language is consistent with the duty to provide reasonable assistance as specified in 2695.5(e)(2). The regulation intends to require an affirmative responsibility of the insurer to perform a diligent investigation. The law is clear that a minimum standard for claims investigation is "thorough, fair and objective".

Comment No.: **29**
Section: **2695.7(d)**
Commentator: **State Farm Insurance Companies, Steve McManus**
Date of comment: **5/9/02**
Type of comment: **Written**

Summary of comment: The following is an exact excerpt from the commentator's verbiage "Insurers would be required to "conduct and diligently pursue a thorough, fair and objective investigation. This standard does not appear to be statutorily authorized. We view this language as a new standard of conduct in bad faith and unfair competition actions." The proposed new standard is inconsistent with existing case law.

Response to Comment: The commissioner considered the comment and rejects it. The requirement "to **conduct and diligently pursue a thorough, fair and objective investigation**" is not a new standard nor is it unclear. It is authorized by case law, specifically *Egan v. Mutual of Omaha* (1979) 24 Cal.3d 809, as cited in the "Note" section below. While the opinion expressly employs only the term "thorough," the "diligent," "fair" and "objective" standards are consistent with the implied covenant of good faith and fair dealing. The Egan Court found that covenant to require "each contracting party to refrain from doing anything to injure the right of the other to receive the benefits of the agreement" *(Id.*, at p. 818), that "the insurer, when determining whether to settle a claim, must give at least as much consideration to the welfare of its insured as it gives to its own interests" (*Id.*), and that "an insurer fully inquire into possible bases that might support the insured's claim" (*Id.*, at p. 819).

These well-settled legal tenets, together with the statutory requirement of "prompt investigation" (Cal.Ins.Code, sec.790.03(h)(3)), authorize the language in Section 2695.7(d).

Comment No.: **11**
Section: **2695.7(d)**
Commentator: **Association of California Insurance Companies, Jeffrey J. Fuller**
Date of comment: **5/7/02**
Type of comment: **Written**

Summary of comment: The proposed language should require a "reasonably" thorough, fair and objective investigation. Otherwise the duty imposed on insurers arguably would be to

pursue investigations that achieve perfection. Furthermore, "this subsection would establish verbal handcuffs which reflect an attempt to inhibit insurers from pursuing apparently fraudulent claims." Additionally, there can never be a correct answer as to when it is appropriate to end the investigation process.

Response to comment: The commissioner considered the comment and rejects it. The new language is consistent with, and adds clarity to, CIC Section 790.03(h)(3) which requires prompt investigation and is consistent with the duty to provide reasonable assistance as prescribed by 2695.5(e)(2). The regulation intends to require an affirmative responsibility by the insurer to perform a diligent investigation without enumerating each and every step or method used to perform the requisite investigation. Investigation needs will vary on a case by case basis.

Comments Re: SECTION 2695.7(e)

Comment No.: **29**
Section: **2695.7(e)**
Commentator: **State Farm Insurance Companies, Steve McManus**
Date of comment: **5/9/02**
Type of comment: **Written**

Summary of comment: Commentator refers to comments made to 2695.1(c) as a basis to delete surety from this subsection. Surety should be deleted because the surety's primary obligation is always to the principal. The surety's obligation to perform is secondary and requires proof of default by the principal before the obligation even begins to exist. This process and the proof required of the obligee can become lengthy and very detailed. Surety claims are complex and the timeframes in 2695.7 are highly impractical and commercially unreasonable. Further, the proposed language fails to recognize the duty of a principal to perform under a surety bond as the primary duty in the contract. The proposed language is not consistent with common law.

Response to comment: The commissioner considered the comment and rejects it**.** The proposed language allows the surety to compel the principal to perform the obligation and is not inconsistent with existing statutes as they apply to surety. Note: the proposed language specifically states "…except as may otherwise be provided by policy provisions, **statutes,** or regulations…". Emphasis added.

Comment No.: **4**
Section: **2695.7(e)**
Commentator: **John Metz**
Date of comment: **4/30/02**
Type of comment: **Written**

Summary of comment: The language at the end of the subsection which reads "including those pertaining to coordination of benefits" should be deleted as it is redundant.

Response to comment: The commissioner considered the comment and rejects it. The language adds specificity as respects its application to coordination of benefits and is not redundant.

Comment No.: **16**

Section: **2695.7(e)**
Commentator: **Developers Surety and Indemnity Company**
Robins, Kaplan, Miller & Ciresi LLP, David C. Veis
Date of comment: **5/8/02**
Type of comment: **Written**

Summary of comment: The proposed language is contrary to case law that allows a surety to await determination of a legitimate dispute between the principal and the claimant and it is also contrary to the authority which stays a claim made against a surety while the principal and the claimant are in arbitration.

Response to comment: The commissioner considered the comment and rejects it. Nothing in the proposed language precludes a surety from exercising its rights under existing statutes and related case law. Note: the proposed language specifically states "…except as may otherwise be provided by policy provisions, **statutes,** or regulations…" Emphasis added. Further, if the surety needs more time to make a determination, it may avail itself of subsection 2695.7(c)(1).

Comments Re: SECTION 2695.7(f)

Comment No.: **13**
Section: **2695.7(f)**
Commentator: **PIF, G. Diane Colborn**
Date of comment: **5/7/02**
Type of comment: **Written and Oral**

Summary of Comment: The removal of language which precludes companies from notifying the claimant of statute of limitations is unnecessary and illogical. An insurer is not permitted to communicate directly with a claimant who is represented. Therefore, the company would be required to advise the attorney of limiting statutes, which the attorney is obligated to know as a part of providing competent counsel. Insurers should not be required to compensate for incompetent counsel.

Response to Comment: The commissioner has considered the comment and accepts it. The proposed regulation will be amended to restore the deleted language.

Comment No.: **15**
Section: **2695.7(f)**
Commentator: **Surety Association of America**
Sedgwick, Detert, Moran & Arnold
Marilyn Klinger
Date of comment: **5/8/02**
Type of comment: **Written**

1. Summary of comment: There is an inconsistency and a redundancy between the proposal combining Section 2695.4(a) and 2694.4(b), and the proposed section 2695.7(f).

Response to comment: The commissioner considered the comment rejects it. These sections complement each other in that 2695.4(a) prohibits an insurer from misrepresenting, concealing

or failing to disclose coverage and time limits etc. while 2695.7(f) sets specific time limits for providing written notice of any statute of limitation or other time period requirements upon which the insurer may rely upon to deny a claim. These sections are neither inconsistent nor redundant.

Comment No.: **4**
Section: **2695.7(f)**
Commentator: **John Metz**
Date of comment: **4/30/02**
Type of comment: **Written**

Summary of comment: As the insurer and claimant may have different interpretations of the meaning and/or effect of the tolling and time period requirements the following additional language is recommended:

"…Such notice shall be given to the claimant not less than sixty (60) days prior to the expiration date **'and shall include an explanation of any tolling of any time period requirement that may apply';…"**

Response to comment: The commissioner has considered the comment and rejects it. The recommended modifications are substantive and would completely change the focus of the insurer's responsibility to a claimant which is outside the current scope of the regulations and therefore should be considered during the next phase of the review and modification process.

Comment No.: **38**
Section: **2695.7(f)**
Commentator: **American Insurance Association, Bill Gausewitz**
Date of comment: **5/9/02**
Type of comment: **Written**

Summary of Comment: The removal of language which precludes companies from notifying the claimant of statute of limitations is illogical and unauthorized by the claims practice statutes. An insurer is not permitted to communicate directly with a claimant who is represented. A claimant's attorney is professionally obligated to understand and comply with the statutes of limitations.

Response to Comment: The commissioner has considered the comment and accepts it. The proposed regulation will be amended to restore the deleted language.

Comment No.: **18**
Section: **2695.7(f)**
Commentator: **National Association of Independent Insurers, Sam Sorich**
Date of comment: **5/8/02**
Type of comment: **Written**

Summary of comment: The deleted language should be added back to the proposed regulations. (Similar to Comment 38 for this subsection).

Response to comment: The commissioner considered the comment and accepts it. The deleted language will be added back to the regulations.

Comment No.: **28**
Section: **2695.7(f)**
Commentator: **CSAA, Douglas A. Lutgen**
Date of comment: **5/9/02**
Type of comment: **Written**

Summary of comment: Proposed revisions would improperly require insurers to notify represented claimants of impending statutes of limitations expirations.

Response to comment: The commissioner considered the comment and accepts it. The deleted language will be restored. See response to PIF.

Comment No.: **35**
Section: **2695.7(f)**
Commentator: **21st Century Insurance Company, Barger & Wolen LLP, Kent R. Keller**
Date of comment: **5/7/02**
Type of comment: **Written**

Summary of comment: This amendment is unnecessary as the insured expects legal advice on limitations periods from his attorney, and the insurer may not communicate with a represented insured. The language is also inconsistent with Section 11580.2 of the insurance code.

Response to comment: The commissioner considered the comment and accepts it. See response to PIF.

Comment No.: **37**
Section: **2695.7(f)**
Commentator: **Farmers Insurance Group, Bennett L. Katz**
Date of Comment: **5/14/02**
Type of Comment: **Written**

Summary of comment: The proposed language is not necessary if claimant is represented by counsel since there is no risk of being mislead as to the applicable statute of limitations. In addition, the current language, that exempts the notice requirement when a claimant is represented by counsel, is a much more effective approach to effectuate the purpose of the statute and is less burdensome to carriers.

Response to comment: The commissioner considered the comment and accepts it. The deleted language will be restored. See response to PIF.

Comment No.: **29**
Section: **2695.7(f)**

Commentator: **State Farm Insurance Companies, Steve McManus**
Date of comment: **5/9/02**
Type of comment: **Written**

Summary of comment: Proposed language would require an insurer to notify a claimant represented by counsel that the statute of limitations for bringing a claim was about to be triggered. This change is not statutorily authorized or necessary and inconsistent with the policy objective of reducing litigation that is cited in the statement of intent. The proposed change would likely increase litigation over time limitations periods and give rise to additional proof of mailing disputes.

Response to comment: The commissioner considered the comment and accepts it. The deleted language will be restored. See PIF.

Comment No.: **16**
Section: **2695.7(f)**
Comment: **Developers Surety and Indemnity Company**
Robins, Kaplan, Miller & Ciresi LLP, David C. Veis
Date of comment: **5/8/02**
Type of comment: **Written**

Summary of comment: The changes to this subsection are redundant to proposed Section 2695.4. Additionally, it is "impracticable" and often impossible for the surety determine the statute of limitations within the time frame required. Often the statutes involve a complicated set of factors and factual scenarios of which the surety has no knowledge. Applying this section to a surety is inconsistent with the unique aspects of suretyship.

Response to comment: The commissioner considered the comment and rejects it. While it may be true that some surety statutes are particularly complex, this is precisely the reason why the surety needs to communicate this information to the claimant. The surety is in a superior position to understand and know how such statutes apply to a specific claim. Although the tripartite relationship that exists in connection with a surety bond is unique, statutory and case law does not preclude the application of these regulations to surety claims. The proposed amendment is necessary because the minimum standards for settling claims are as applicable to surety as to other types of claims. These minimum standards work to protect the claimant regardless of the complexity of the claim.

Comment No.: **11**
Section: **2695.7(f)**
Commentator: **Association of California Insurance Companies, Jeffrey J. Fuller**
Date of comment: **5/7/02**
Type of comment: **Written**

Summary of comment: The requirements of this section should only apply in instances where the claimant is not represented by counsel.

Response to comment: The commissioner considered the comment and accepts it. Refer to response to PIF.

Comments Re: SECTION 2695.7(g), generally

Comment No.: **4**
Section: **2695.7(g), generally**
Commentator: **John Metz**
Date of comment: **4/30/02**
Type of comment: **Written**

Summary of comment: Commentator proposes entirely new subsection, Section 2695.7(g)(8).

Response to comment: Commissioner considered the comment and rejects it. The recommendation is outside the scope of the rulemaking.

Comments Re: SECTION 2695.7(g)(1)

Comment No.: **4**
Section: **2695.7(g)(1)**
Commentator: **John Metz**
Date of comment: **4/30/02**
Type of comment: **Written**

Summary of comment: The primary goal of claims settlement is to establish the value not to support or dispute it. For this reason, the following language is recommended:

"(1) the extent to which the insurer considered evidence submitted by the claimant to **'establish ~~support~~**' the value of the claim;"

Response to comment: The commissioner considered the comment and rejects it. The recommendation is outside the scope of the rulemaking. Further the recommended language is unnecessary.

Comments Re: SECTION 2695.7(g)(2)

Comment No.: **4**
Section: **2695.7(g)(2)**
Commentator: **John Metz**
Date of comment: **4/30/02**
Type of comment: **Written**

Summary of comment: To reflect the three fold bases required in virtually in all claims decisions: the facts, law and policy provisions, the following language should be added to this subsection:

"(2) the extent to which the insurer consider legal authority, **'policy language and other'** evidence made know to it or reasonably available..."

Response to comment: The commissioner considered the comment and rejects it. The language of the proposed regulation does not preclude an insurer from considering policy language as "evidence" to support the processing of claims. Adding the recommended language is not necessary.

Comment No.: **18**
Section: **2695.7(g)(2)**
Commentator: **National Association of Independent Insurers, Sam Sorich**
Date of comment: **5/8/02**
Type of comment: **Written**

Summary of comment: The term "legal authority" is undefined and unclear and would subject an insurer to arbitrary regulatory actions because the insurer would not know for sure whether it must look at statutes, appellate decisions, regulations and /or trial court decisions. Claims adjusters are not attorneys. As written, the proposed language would require that every claim must be handled by a person who has broad knowledge of all possible legal authority. Decisions by claims adjusters would likely be considered unreasonable.

Response to comment: The commissioner considered the comment and rejects it. The subsection adds no requirement that the insurer consider legal authority but when such authority is used as a basis for a settlement offer, that authority may be submitted by the insurer for consideration by the commissioner. It would not, however, be unreasonable for the commissioner to expect insurers to be kept apprised of important developments in the law regarding standards for claims handling, whether those standards are contained in the statutory or case law.

Comment No.: **35**
Section: **2695.7(g)(2)**
Commentator: **21st Century Insurance Company, Barger & Wolen LLP, Kent R. Keller**
Date of comment: **5/7/02**
Type of comment: **Written**

Summary of comment: This amendment would improperly require insurers to disclose confidential attorney-client opinions and communications.

Response to comment: The commissioner considered the comment and rejects it. The subsection adds no requirement that the insurer consider legal authority but when such authority is used as a basis for a settlement offer, that authority may be submitted by the insurer for consideration by the commissioner. However, if the insurer chooses not to disclose this information it may do so.

Comment No.: **37**
Section: **2695.7(g)(2)**
Commentator: **Farmers Insurance Group, Bennett L. Katz**
Date of Comment: **5/14/02**
Type of Comment: **Written**

Summary of comment: The sections lacks clarity with respect to the language reading "…legal authority…" Language is confusing and unclear as to the scope of legal authority. For clarity the amendment should read "…applicable legal authority…"

Response to comment: The commissioner considered the comment and rejects it. See response to NAII.

Comment No.: 11
Section: 2695.7(g)(2)
Commentator: Association of California Insurance Companies, Jeffrey J. Fuller
Date of comment: 5/7/02
Type of comment: Written and Oral

Summary of comment: Although adjusters are aware of the basic rules regarding tort and insurance law, they are not lawyers and should not be forced into debating the legal merits of claims with claimants or their lawyers. "What if an adjuster fairly settles a claim but in reliance on faulty legal authority? Would that be an unfair claim practice? Why?". This section could be read to require insurers to do legal research prior to acting on a claim.

Response to comment: The commissioner considered the comment and rejects it. Refer to response to NAII. Further, an insurer holds a superior position in the claims handling process and should have knowledge of the statutes, case law and other legal authority it uses to settle a claim. With respect to the commentator's specific questions, an adjuster relying on faulty legal authority to settle a claim, has not "fairly" settled the claim and may be in violation of the Act or regulations.

Comment No.: 26
Section: 2695.7(g)(2)
Commentator: Safeco, Ruben Cruz
Date of comment: 5/9/02
Type of comment: Written

Summary of comment: Comment is similar to NAII Comment #18 for this subsection, above.

Response to comment: The commissioner considered the comment and rejects it. See response to NAII Comment #18 for this subsection, above.

Comments Re: SECTION 2695.7(g)(5)

Comment No.: 4
Section: 2695.7(g)(5)
Commentator: John Metz
Date of comment: 4/30/02
Type of comment: Written

Summary of comment: Commentator proposed entirely new section 2695.7(g)(5) to replace current 2695.7(g)(5).

Response to comment: Commissioner considered the comment and rejects it. The recommendation is outside the scope of the rulemaking.

Comments Re: SECTION 2695.7(g)(7)

Comment No.: **13**
Section: **2695.7(g)(7)**
Commentator: **PIF, G. Diane Colborn**
Date of comment: **5/7/02**
Type of comment: **Written**

Summary of Comment: The change in language will discourage partial payments, opening up the possible interpretation that incremental payments can be termed "low-balling" if and when later payments are made.

Response to Comment: The commissioner has considered the comment and rejects it. The proposed language intends to prevent insurance companies from offering unfair low settlements. Nothing contained in the proposed subsection prevents a company from making partial fair settlement offers.

Comment No.: **28**
Section: **2695.7(g)(7)**
Commentator: **CSAA, Douglas A. Lutgen**
Date of comment: **5/9/02**
Type of comment: **Written**

Summary of comment: As a claim matures over time it may be that the insurer acquires more and more information that supports an increasingly higher claim value. The proposed language makes no accommodation for this situation. The adequacy of any settlement offer must be judged by the facts and circumstances that were known at the time the offer was made. If an insurer were to operate under the proposed regulations, it could be acting at its peril to make any settlement offer unless and until it had explored and exhausted all potential opportunities to learn of additional elements to the claim, no matter how anxious the insured or claimant might be to settle the claim rapidly.

Response to comment: The commissioner considered the comment and rejects it. Nothing in the proposed language precludes an insurer from offering what it deems to be a fair settlement. The language only allows the commissioner to consider the information available to the insurer at the time settlement was offered to determine whether or not an insurer has offered an "unreasonably low" settlement. Nor does the proposed language prohibit timely settlements of claims.

Comment No.: **35**
Section: **2695.7(g)(7)**
Commentator: **21st Century Insurance Company, Barger & Wolen LLP, Kent R. Keller**
Date of comment: **5/702**
Type of comment: **Written**

Summary of comment: The amendment fails to recognize the negotiation process inherent in claims investigations, and will cause insurers to refrain from making early settlement offers, to the detriment of claimants.

Response to comment: The commissioner considered the comment and rejects it. Refer to response to CSAA.

Comment No.: **29**
Section: **2695.7(g)(7)**
Commentator: **State Farm Insurance Companies, Steve McManus**
Date of comment: **5/9/02**
Type of comment: **Written**

Summary of comment: It is improper for CDI to actively participate in the claim settlement process. The proposed change would change the role of the regulator to mediator, appraiser or arbitrator of an on-going claim. This is an improper role for the regulator to assume and is not statutorily authorized. The commentator refers to the deletion of the words "the final" from the regulations.

Response to comment: The commissioner considered the comment and rejects it. The proposed language does not change the commissioner's role as a regulator. This subsection specifically addresses the facts the commissioner may consider when determining whether or not a settlement offer is unreasonably low. Additionally, nothing in the proposed language for this subsection places the commissioner into a role of a mediator, appraiser, or arbitrator. However, the commentator is reminded that the commissioner, by statute CIC 12921.4, may mediate claims. However, mediation of claims is not part of this subsection.

Comment No.: **11**
Section: **2695.7(g)(7)**
Commentator: **Association of California Insurance Companies, Jeffrey J. Fuller**
Date of comment: **5/7/02**
Type of comment: **Written**

1. Summary of comment: The following is the exact comment:

"There is no reason to delete the word "final" in this section. Regardless of the negotiating process that occurs during settlement negotiations, it is only the final settlement offer that ought to be the basis for assessing the insurers settlement practices. While insurers must be reasonable in the negotiating process, including initial settlement offers, previous settlement offers should become moot in terms in assessing the insurer's claims settlement practices if a claim is finally settled. This should be the rule even where claimants are represented by counsel who have been known to make offers that may be unreasonable high.

Offers preceding the final offer should be irrelevant. Where the case is settled, that settlement should be deemed reasonable. Where case is not settled but proceeds to court, the final judgment should serve as a gauge of reasonableness. Offers made and rejected during settlement negotiations should be of no interest to the department when claims are ultimately settled."

Response to comment: The commissioner considered the comment and rejects it. The proposed language in 2695.7(g) intends to prevent insurers from offering unfair low settlements throughout the negotiation process. Subsection 2695.7(g)(7) is designed to allow an insurer to submit evidence to the commissioner that an amount offered during the negotiation process was, in fact, fair and not low.

2. Summary of comment: "As a final note on this section, under the proposed definition of "proof of claim" an insurer would be obligated to make a reasonable offer based upon information not available to it because the claimant has withheld evidence…."

Response to comment: The commissioner considered the comment and rejects it. Nothing contained in the proposed language requires an insurer to make a settlement offer if more information is needed. The commentator is referred to Subsection 2695.7(b) & (c)(1).

Comments Re: SECTION 2695.7(h)

Comment No.: 13
Section: 2695.7(h)
Commentator: PIF, G. Diane Colborn
Date of Comment: 5/7/02
Type of Comment: Written and Oral

1. Summary of Comment: The changes in the first two sentences of this section require partial advance payment on third party claims without a release. The proposed changes are in conflict with case law, specifically a footnote in Trujillo v. Yosemite-Great Falls Ins. Co. (1984) 153 Cal.App.3d 26, 29, fn.2 [200 Cal.Rptr. 26].

Response to Comment: The commissioner has considered the comment and rejects it. This regulation does not require an advance partial payment without a release of liability. Nothing contained in the proposed language requires the insurer to accept the claim if the insurer needs additional information (see §2695.7(c)(1)). Additionally, Section 2695.7(h) allows an insurer to require a release of all claims when necessary. Therefore, the insurer may require a release in order to actually tender payment.

The new language simply requires payment of that part of the claim that has been accepted. For instance, if an insurer accepts the property damage portion of a third party auto claim, the proposed language requires the insurer to tender payment upon receipt, if the insurer believes it is necessary, of a properly executed release of that portion of the claim. If the bodily injury portion of the same claim is ongoing, the insurer is under no obligation to pay that part of the claim until a release is signed.

Nothing in Trujillo indicates that the proposed language is inconsistent or conflicts with existing case law. (Moreover, Moradi-Shalal v. Fireman's Fund Ins. Cos. (1988) 201 Cal. App. 3d 1122 [226 Cal.Rptr. 333 at pp.337-338] overturned much of the findings in Trujillo.)

2. Summary of Comment: The comment is repeated here verbatim instead of in summary:

"The changes proposed in this subsection are particularly troublesome due to the proposed *deletion* of existing language providing that payment is required ***if*** *the payment would terminate the insurer's known liability under that individual coverage, unless impairment of the insured's interests would result.* The striking of this qualification, if interpreted to require partial advance payment without a release, is in direct conflict with existing case law. It is also inconceivable why the Department would propose to strike the reference to impairment of the insured's interest. The proposed changes are especially objectionable when applied to third party claims, and reflect a misunderstanding of the nature of the settlement process. This provision, like subsection (g)(7), could also have a chilling effect on settlements if interpreted to force an insurer to pay any offer as an "accepted amount." (Emphasis in original.)

Response to Comment: The commissioner has considered the comment and accepts it. While the commentator does not provide authority for its statement, the commissioner agrees that the deleted language, "if payment would terminate the insurer's known liability under that individual coverage, unless impairment of the insured's interests would result," should be reinserted.

Comment No.: 14
Section: 2695.7(h)
Commentator: Mercury Insurance Group, Douglas Hallett, General Counsel
Date of Comment: 2/19/02 attached to 5/8/02 Mercury Comments
Type of Comment: Written

1. Summary of Comment: An insurer has an obligation to protect its insured from further litigation and therefore cannot, as a matter of law, help fund a claimant's pursuit of such insured. This applies equally in Uninsured Motorist claims. Proposed language does not adequately recognize the insurer's responsibility to defend its insured. Section should be amended to recognize insurer's statutory right to make a confidential offer of compromise settlement. The following language should be added to the end of proposed language:

"Nothing herein may be interpreted to interfere with an insurer's right to make a confidential offer of compromise settlement under *California Evidence Code,* Sections 1115-1128 and 1152(a). Nor does an offer of compromise settlement trigger any partial payment obligation".

Response to Comment: The commissioner has considered the comment and rejects it. Nothing in the proposed language interferes with an insurer's right to make a confidential offer of compromise settlement. Nor does the proposed language compromise the insurer's duty to defend obligations. In addition see response to PIF comments.

2. Summary of Comment: The authority cited by the commissioner should include 790.03(h)(12) which requires insurers to settle claims "promptly, even partially, claims where, under one portion of a coverage, they are clearly liable rather than using a failure to settle as a means to influence resolution of other coverage issues." The amended regulation should clarify, not obscure, the distinction the underlying statute recognizes.

Response to Comment: The commissioner has considered the comment and accepts it. CIC 790.03(h)(12) shall be added as authority.

3. Summary of Comment: Regulation fails to recognize that offers of compromise settlement are based on an affirmation of coverage or liability. The regulation should, but doesn't, recognize the alternative approach outlined in CIC 790.03(h)(13) which allows for offers of compromise settlement. Such offers of compromise settlement should not trigger a partial payment obligation under 790.03(h)(13).

Response to Comment: The commissioner has considered the comment and rejects it. Nothing in the proposed regulation requires payment of claim without requiring a release when necessary. See comments to PIF. Further, there is nothing in the statute that interferes with the insurer's ability to make a compromise settlement offer with or without a release. Nor does the language preclude an insurer from actually making partial payments of accepted amounts as required by the regulation. The partial payment obligation required by the regulation, as it applies to compromise settlement proposals, is subject to interpretation on a case by case basis.

Comment No.: **4**
Section: **2695.7(h)**
Commentator: **John Metz**
Date of comment: **4/30/02**
Type of comment: **Written**

1. Summary of comment: To clarify that an insurer is not entitled to demand a release except where such right is granted to it by policy language, the following language should be added to this subsection:

"(h) Upon acceptance of the claim in whole and in part and when **'required by the policy's language'**, upon receipt of a properly executed release…"

Response to comment: The commissioner has considered the comment and rejects it. The intent of this subsection is to specifically allow an insurer to require a release when necessary and pay claims in a timely manner. Any attempt to require that an insurer may only request a release when policy language permits is inconsistent with the intent of this subsection.

2. Summary of comment: The 30 day time limit allowed by the regulation to tender payment or otherwise take action is unreasonable and permits lengthy delays allowing insurers to benefit from retaining the money and/or not incurring the additional costs of meeting its other obligations. The time should be reduced to 15 days.

Response to comment: The commissioner has considered the comment and rejects it. The regulations already include an "immediately" standard which is sufficient to address the commentator's concerns.

Comment No.: **38**
Section: **2695.7(h)**
Commentator: **American Insurance Association, Bill Gausewitz**
Date of comment: **5/9/02**
Type of comment: **Written**

1. Summary of comment: Requiring an insurer to pay any portion of a claim that is not in dispute is inconsistent with an insurer's legal duty to protect its insured.

Response to comment: The commissioner considered the comment and rejects it. This regulation does not require an advance partial payment without a release of liability, if necessary. Refer to response to PIF comments.

2. Summary of comment: The proposed language improperly deletes current exemption for 30 day payment period in cases where "impairment of the insured's interests would result."

Response to comment: The commissioner considered the comment and accepts it. The deleted language will be restored. See response to PIF comments.

3. Summary of comment: The proposed regulation mandates that "in claims where multiple coverage is involved…amounts that have been accepted by the insurer shall be paid immediately." This is true even if the claimant doesn't want the partial payment. Claimants, even those represented by attorneys, frequently balk at partial payments.

Response to comment: The commissioner considered the comment and rejects it. Nothing in the proposed language requires an insurer to force the claimant to accept payment if they don't want it.

Comment No.: **18**
Section: **2695.7(h)**
Commentator: **National Association of Independent Insurers, Sam Sorich**
Date of comment: **5/8/02**
Type of comment: **Written and Oral**

Summary of comment: The proposed language improperly deletes current exemption for 30 day payment period in cases where "impairment of the insured's interests would result."

Response to comment: The commissioner considered the comment and accepts it. The deleted language will be restored. See response to PIF comments.

Comment No.: **35**
Section: **2695.7(h)**
Commentator: **21st Century Insurance Company, Barger & Wolen LLP, Kent R. Keller**
Date of Comment: **5/7/02**
Type of Comment: **Written**

1. Summary of comment: This amendment is inconsistent with existing law and would open insurers up to claims of failing to protect the insured's interest. The amendment may require payment even where the "accepted" amount does not terminate the insured's liability under an individual coverage and before a release can be obtained on behalf of the insured.

Response to comment: The commissioner considered the comment and rejects it. Nothing precludes an insurer from requiring a release in order to pay the claim. See response to PIF.

2. Summary of comment: The amendments require insurers, in cases of multiple claimants, to tender payment to the first claimant to come forward, even though the first claimant may not have suffered the most damage. In the event of further claims, the insured could charge the insurer with failure to protect its interests.

Response to comment: The commissioner considered the comment and rejects it. Nothing in the proposed language precludes an insurer from protecting the interests of its insured. In cases where there are multiple claimants, nothing precludes the insurer from taking the necessary steps to protect its insured interests which may include filing an Interpleader.

3. Summary of comment: The proposed language shows a misunderstanding of the process, which in many cases is a give-and-take negotiation. If insurers are required to pay any amount accepted, then the Department could interpret the regulation to require incremental payments as the negotiation proceeds.

Response to comment: The commissioner considered the comment and rejects it. This regulation does not require an advance partial payment without a release of liability. Further, deleted language in the proposed regulation will be restored. See response to PIF.

Comment No.: 29
Section: 2695.7(h)
Commentator: State Farm Insurance Companies, Steve McManus
Date of comment: 5/9/02
Type of comment: Written

Summary of comment: The comments are similar to PIF. Refer to PIF.

Response to comment: See response to PIF.

Comment No.: 11
Section: 2695.7(h)
Commentator: Association of California Insurance Companies, Jeffrey J. Fuller
Date of comment: 5/7/02
Type of comment: Written

Summary of comment: Objects to the deletion of the language "…unless impairment of the insured's interest would result."

Response to comment: The commissioner considered the comment and accepts it. Refer to response to PIF.

Comment No.: 9
Section: 2695.7(h)
Commentator: Home Warranty Association
Stoel Rives LLP
Sean E. McCarthy
Date of comment: 5/7/02
Type of comment: Written

Summary of comment: Home protection contracts do not pay claims. There exists no "claim obligation" in a service contract, rather there exists a service obligation. In instances where repair is necessary, such repairs are generally completed well within a 30 day time frame, however, in the event that replacement parts are required and are ordered from an appliance or system manufacturer, the delivery of the parts is not subject to the control or action of the home protection company.

Response to comment: The commissioner considered the comment and rejects it. The proposed language specifically states that " Upon acceptance of the claim…**or otherwise take action to perform its claim obligation**…". Emphasis added. This language is applicable to service contracts i.e. the service performed **is** the claims obligation. The problems cited by the commentator as to time frame are similar problems encountered in other lines of insurance where repair parts have been ordered but are not readily available. See response to subsection 2695.1(d).

Comment No.: **Oral - See Transcript in Rulemaking File**
Section: **2695.7(h)**
Commentator: **Sonnenschein, Nath and Rosenthal, Gary Hernandez**
Date of Comment: **5/8/02**
Type of Comment: **Oral - See Transcript in Rulemaking File**

Summary of Comment: Proposed subsection interprets policy language and requires advance payments and partial payments.

Response to Comment: The commissioner has considered the comment and rejects it.
See response to PIF.

Comment No.: **Oral - See Transcript in Rulemaking File**
Section: **2695.7(h)**
Commentator: **Mercury Insurance Group, Mark Levine**
Date of Comment: **5/9/02**
Type of Comment: **Oral - See Transcript in Rulemaking File**

Summary of Comment: Comments similar to those made in writing by Douglas Hallett, General Counsel for Mercury Insurance Group on 2/19/02 attached to 5/8/02 written comment from Mercury.

Response to Comment: See responses to Douglas Hallett and PIF.

Comments Re: SECTION 2695.7(h)(2)

Comment No.: **4**
Section: **2695.7(h)(2)**
Commentator: **John Metz**
Date of comment: **4/30/02**
Type of comment: **Written**

Summary of comment: With respect to title insurance, commentator recommends changing the time limit for payment from 30 to 15 calendar days after acceptance of a claim.

Response to comment: Comment is outside the scope of the rulemaking.

Comments Re: SECTION 2695.7(i)

Comment No.: 4
Section: 2695.7(i)
Commentator: John Metz
Date of comment: 4/30/02
Type of comment: Written

Summary of comment: To eliminate situations in which an insurer requests information from someone other than a claimant e.g. medical records from a physician, without informing the claimant directly, and to prevent insurers from notifying third parties that the claim will be denied if the insured does not receive the information by a specific date, the following language should be added to the subsection:

"(I) No insurer shall inform a claimant, **'either directly or indirectly'** that his or her rights…"

Response to comment: The commissioner considered the comment and rejects it. The comment is outside the scope of the rulemaking.

Comments Re: SECTION 2695.7(k)

Comment No.: 4
Section: 2695.7(k)
Commentator: John Metz
Date of comment: 4/30/02
Type of comment: Written

Summary of comment: The following additional language is recommended but the reasons are not clear.

"(k) Subject to the provisions of subsection 2695.7(c) where there is a reasonable basis, supported by specific **'verified'** information available for review by the California Department of Insurance…"

Response to comment: The commissioner considered the comment and rejects it. The commentator has not presented a reason for adding this language nor is it clear what would constitute "verified" information. Further, it is unclear who would be responsible for providing "verified" information. Adding this additional language would extend the regulation beyond its present intent which would be a substantive change that could be considered during the next modification to the regulations, provided the commentator submits credible support for the recommendation.

Comments Re: SECTION 2695.7(k)(2)

Comment No.: **4**
Section: **2695.7(k)(2)**
Commentator: **John Metz**
Date of comment: **4/30/02**
Type of comment: **Written**

Summary of comment: To ensure that the good faith belief has a sufficiently objective foundation to protect insureds and insurers from improper claims decisions and unfair competition; to ensure that decisions are based upon accurate information obtained from original sources; and to ensure that there is personal accountability for the accuracy of the information, the following language should be added to this regulation:

"…insurer ca n demonstrate to the commissioner **based on verified documentation from the person(s) upon whose information the allegation is based'** that it has made a diligent attempt to determine whether the subject claim is false or fraudulent…."

Response to comment: The commissioner considered the comment and rejects it. This comment is outside the scope of rulemaking.

Comments Re: SECTION 2695.7(l)

Comment No.: **4**
Section: **2695.7(l)**
Commentator: **John Metz**
Date of comment: **4/30/02**
Type of comment: **Written**

Summary of comment: To ensure that the good faith belief has a sufficiently objective foundation to protect insureds and insurers from improper claims decisions and unfair competition; to ensure that decisions are based upon accurate information obtained from original sources; and to ensure that there is personal accountability for the accuracy of the information, the following language should be added to this regulation:

"(1) No insurer shall deny a claim based upon information obtained in a telephone conversation or personal interview with any source unless the telephone conversation or personal interview is documented in the claim file pursuant to the provisions of Section 2695.3 **'and by verified documentation from the person(s) upon whose information the denial is based'**."

Response to comment: The commissioner considered the comment and rejects it. This comment is outside the scope of rulemaking.

Comments Re: SECTION 2695.7(n)

Comment No. **13**
Section: **2695.7(n)**
Commentator: **PIF, G. Diane Colborn**
Date of comment: **5/7/02**

Type of comment: Written

Summary of Comment: The proposed language precludes an insurer from requiring a medical examination unless there is a specific policy provision authorizing such examination.

Response to Comment: The commissioner has considered the comment, accepts it in part and rejects it in part. The language does not preclude an insurer from requiring a medical examination unless there is a specific policy provision authorizing such examination. The section should apply in any situation in which an insurer requests a medical examination. For clarification, the section will be changed to read as follows:

> Every insurer requesting a medical examination for the purpose of determining liability under a policy provision ~~to pay medical benefits~~ shall do so only when the insurer has a good faith belief that such an examination is **reasonably** necessary ~~to enable the insurer to determine the reasonableness and/or necessity of any medical treatment~~.

Comment No.: 4
Section: 2695.7(n)
Commentator: John Metz
Date of comment: 4/30/02
Type of comment: Written

Summary of comment: To ensure that the good faith belief has a sufficiently objective foundation to protect insureds and honest insurers from improper claims decisions and unfair competition and to ensure that decisions are based upon accurate information obtained from original sources and that there is personal accountability for the accuracy of the information, the following language should be added to this regulation:

"(n) Every insurer requesting a medical examination for the purpose of determining liability under a policy provision authorizing medical examinations by the insurer shall do so only when the insurer has a good faith belief, **'supported by adequate objective, verified evidence in the file,'** that such an examination is reasonable necessary."

Response to comment: The commissioner considered the comment and rejects it. The current language already requires an insurer to have a "good faith belief" that an examination is reasonably necessary. To require further evidence in the file is not necessary.

Comment No.: 18
Section: 2695.7(n)
Commentator: National Association of Independent Insurers, Sam Sorich
Date of comment: 5/8/02
Type of comment: Written

Summary of comment: The proposed changes could be interpreted to mean that an insurer would not be able to ask a third party claimant to be examined because the insurer's policy did not contain a provision authorizing medical examinations.

Response to comment: The commissioner considered the comment and accepts it. The language will be amended to add clarity. See response to PIF, Comment 13, above.

Comment No.: **37**
Section: **2695.7(n)**
Commentator: **Farmers Insurance Group, Bennett L. Katz**
Date of Comment: **5/14/02**
Type of Comment: **Written**

Summary of comments: The proposed language is confusing and unclear as to its applicability of the regulation. Does the language apply to only policies with provisions that authorize medical examinations, or does it also apply to policies that provide such benefits but do not specifically authorize medical examinations.

Response to comment: The commissioner considered the comment and accepts it. The language will be amended to add clarity. See response to PIF, Comment 13, above.

Comment No.: **11**
Section: **2695.7(n)**
Commentator: **Association of California Insurance Companies, Jeffrey J. Fuller**
Date of comment: **5/7/02**
Type of comment: **Written**

Summary of comment: "The purpose of the change in this provision escapes this writer. Is there a concern that insurers are requesting unnecessary medical examinations?"

Response to comment: The commissioner refers the commentator to the Initial Statement of Reasons. Insurers that require unnecessary medical examination is one concern of the commissioner.

Comment No.: **Oral - See Transcript in Rulemaking File**
Section: **2695.7(n)**
Commentator: **Sonnenschein, Nath and Rosenthal, Gary Hernandez**
Date of comment: **5/8/02**
Type of comment: **Oral - See Transcript in Rulemaking File**

Summary of comment: Section would expand coverage requiring the rewriting of policies. Medical examinations are not routinely done but prompted by what appears to be unnecessarily high claim for medical expenses or in response to a suspected fraudulent claim.

Response to comment: The commissioner has considered the comment, accepts it in part and rejects it in part. See response to PIF, above

Comments Re: SECTION 2695.7(o)

Comment No.: **4**
Section: **2695.7(o)**

Commentator: **John Metz**
Date of comment: **4/30/02**
Type of comment: **Written**

Summary of comment: To omit the following proposed language is to limit the scope of the offered protection unreasonably:

"(o) No insurer shall require that a claimant withdraw, rescind or refrain from submitting any complaint to the California Department of Insurance **'or any other governmental or private agency'** regarding the handling of a claim or any other matter complained of as a condition precedent to the settlement of any claim."

Response to comment: The commissioner considered the comment and rejects it. This comment is outside the scope of the rulemaking.

Comments Re: SECTION 2695.7(p)

Comment No.: **29**
Section: **2695.7(p)**
Commentator: **State Farm Insurance Companies , Steve McManus**
Date of comment: **5/9/02**
Type of comment: **Written**

Summary of comment: This section should not apply to surety bonds. There is a common law right of subrogation on all surety claims. The law of surety bonds has never required the surety to pursue an excess loss on behalf of an obligee, nor prorate any recovery.

Response to comment: The commissioner considered the comment and rejects it. This subsection does not apply to surety claims – it applies to first party claimants as defined in the regulations.

Comment No.: **4**
Section: **2695.7(p)**
Commentator: **John Metz**
Date of comment: **4/30/02**
Type of comment: **Written**

Summary of comment: In order to allow the claimant to be able to make a fully informed decision whether to incur the expense and take the risk of pursing a claim against a potentially responsible third party, the following language is recommended:

"(p)…Where an insurer elects not to pursue subrogation, or discontinues pursuit of subrogation, it shall include in its notification a statement that any recovery to be pursued is the responsibility of the first party claimant, **'and that the insurer is or is not relinquishing any subrogation right it holds.'** …"

Response to comment: The commissioner considered the comment and rejects it. The suggested language is unnecessary, as it is implicit in the existing text.

Comments Re: SECTION 2695.7(q)

Comment No.: **31**
Section: **2695.7(q)**
Commentator: **Eileen Shanon, Ingerix**
Date of comment: **5/9/02**
Type of comment: **Written**

1. Summary of Comment: Moving the language to 2695.7(q) makes this regulation applicable to all lines of insurance, including health. Specific concerns are that the terms "proportionate basis" and "pro rata share of the allocated loss adjustment" are not defined. This language also does not address the situation where the deductible has not been paid or has been waived as respects health insurance.

Response to comment: The commissioner considered the comment and accepts it. Subrogation as contained in the proposed language is derived from contractual language specified in most property/casualty insurance policies. Disability insurance will be excluded from this subsection.

2. Summary of comment: Compliance with this regulation will add administrative costs to the health insurers subrogation activities.

Response to comment: The commissioner considered the comment and accepts it. This section shall not apply to health insurance.

Comment No.: **7**
Section: **2695.7(q)**
Commentator: **Underwriters at Lloyd's**
LeBoeuf, Lamb, Greene, & MacRae
Dean Hansell
Date of comment: **5/6/02**
Type of comment: **Written**

Summary of comment: As drafted, the proposed language does not recognize the complexity of multiple policies issued for large commercial insureds. Moreover, the proposed language runs directly counter to arrangements that are typically worked out in commercial policies between insurers and insureds within the ultimate net loss clause or other applicable language. For example, case law and modified policy language allows for subrogation recoveries to be allocated in a manner much different from the proposed regulation. In many instances recoveries are allocated from the "top" down i.e. the insurer at the highest layer of coverage may receive reimbursement long before the lower layer insurers or the insured. Commercial lines should be exempted from this regulation.

Response to comment: The commissioner has considered the comment and accepts it in part and rejects it in part. While the commissioner recognizes that the proposed language may cause confusion or conflict with special subrogation language included in large commercial policies with multiple insurers, smaller commercial lines insureds need the protection of this regulation and would benefit from the proposed language. The following modification to the proposed language is recommended:

(added to the end of 2695.7(q). <u>This subsection shall not apply when multiple policies have been issued to the insured(s) and the language of these contracts prescribe alternative subrogation rights.</u>

<u>Comment No.</u>: 4
Section: 2695.7(q)
Commentator: John Metz
Date of comment: 4/30/02
Type of comment: Written

Summary of comment: In order to avoid situations in which an insurer retains sums to which the first party claimant is entitled, the following additional language is recommended:

"(q) Every insurer shall share subrogation recoveries on a proportionate basis with the first party claimant, unless the first party claimant has otherwise recovered the whole deductible amount **<u>', except when such recovery is subject to the 'collateral source' or other applicable rule permitting such recovery without sharing the benefit with the insurer.'</u>**…"

Response to comment: The commissioner considered the comment and rejects it. It is unclear as to what the additional language would accomplish as respects protecting the insureds right to recover their deductible. The current proposed language is sufficient to protect the insured's interest.

<u>Comment No.</u>: 29
Section: 2695.7(q)
Commentator: State Farm Insurance Companies, Steve McManus
Date of comment: 5/9/02
Type of comment: Written

Summary of comment: This section should not apply to surety bonds. There is a common law right of subrogation on all surety claims. The law of surety bonds has never required the surety to pursue an excess loss on behalf of an obligee, nor prorate any recovery.

Response to comment: The commissioner considered the comment and rejects it. This subsection does not apply to surety claims – it applies to first party claimants as defined in the regulations.

<u>Comments Re: SECTION 2695.7(r)</u>

<u>Comment No.</u>: 13
Section: 2695.7(r)
Commentator: PIF, G. Diane Colborn
Date of comment: 5/7/02
Type of comment: Written

Summary of Comment: The purpose of the proposed language is unclear. Insurers have no incentive to inappropriately pursue subrogation.

Response to Comment: The commissioner has considered the comment and rejects it. The proposed language simply requires an insurer to not pursue subrogation claims that do not have merit. Furthermore, the proposed regulation complements proposed 2695.7(d), which requires a thorough investigation. Finally, the regulation is not intended to protect an insured; it is intended to protect a consumer from inappropriate pursuit by an insurance company. It is the practice of some insurers to report consumers to collection agencies without adequately investigating the merits of subrogation.

Comment No.: **7**
Section: **2695.7(r)**
Commentator: **Underwriters at Lloyd's**
LeBoeuf, Lamb, Greene, & MacRae
David Hansell
Date of comment: **5/6/02**
Type of comment: **Written**

Summary of comment: The standard for a "thorough, fair and objective investigation" is too vague and can lead to potential third party allegations that the insurer should have carried out a "thorough" investigation before pursuing what may turn into an unsuccessful subrogation.

Response to comment: The commissioner considered the comment and rejects it. The language of the proposed regulation intends to require that an insurer perform a thorough investigation prior to pursuing subrogation. It is intended to protect a consumer from inappropriate pursuit by an insurance company. It is the practice of some insurers to report consumers to collection agencies without adequately investigating the merits of subrogation.

Comment No.: **18**
Section: **2695.7(r)**
Commentator: **National Association of Independent Insurers, Sam Sorich**
Date of comment: **5/8/02**
Type of comment: **Written**

Summary of comment: The standard for a "thorough" and "objective investigation" is too vague.

Response to comment: The commissioner considered the comment and rejects it. The language of the proposed regulation intends to require that an insurer perform a thorough investigation prior to pursuing subrogation without dictating or enumerating each and every step used to perform the requisite investigation. It is the practice of some insurers to report consumers to collection agencies without adequately investigating the merits of subrogation. There is no need to define the terms cited as investigation needs will vary on a case by case basis.

Comment No.: **35**
Section: **2695.7(r)**
Commentator: **21st Century Insurance Company, Barger & Wolen LLP, Kent R. Keller**
Date of comment: **5/7/02**
Type of comment: **Written**

1. **Summary of comment:** This amendment is inconsistent with existing law, as subrogation is the insured's right under the policy.

   Response to comment: The commissioner considered the comment and rejects it. Contrary to commentator's statement, subrogation is the "insurer's" right, not the "insured's".

2. **Summary of comment:** The amendment is also unclear and will promote inconsistent enforcement.

   Response to comment: The commissioner considered the comment and rejects it. See response to NAII and PIF.

3. **Summary of comment:** The proposed language would protect a class of persons not protected under the unfair practices act and may open insurers up to claims of improper subrogation or failure to subrogate, whereas subrogation should be in the discretion of the insurer.

   Response to comment: The commissioner considered the comment and rejects it. The proposed language is in keeping with the commissioner's responsibility to promulgate regulations that promote good faith, prompt, efficient and equitable settlement of claims. The language intends to protect a consumer from inappropriate pursuit by an insurance company. It is the practice of some insurers to report consumers to collection agencies without adequately investigating the merits of subrogation.

Comment No.: **29**
Section: **2695.7(r)**
Commentator: **State Farm Insurance Companies, Steve McManus**
Date of comment: **5/9/02**
Type of comment: **Written**

Summary of comment: The proposed section is inconsistent with applicable claim handling investigation standards and is without legal authority. It appears CDI is trying to inhibit subrogation recoveries from uninsured parties, since subrogation is appropriate when an insurer pays a claim presented by its insured and said claim was caused by the negligence of a third party. It is poor public policy to put the interests of illegally uninsured drivers above the interests of insurance consumers.

Response to comment: The commissioner considered the comment and rejects it. See response to PIF.

Comment No.: **11**
Section: **2695.7(r)**
Commentator: **Association of California Insurance Companies, Jeffrey J. Fuller**
Date of comment: **5/7/02**
Type of comment: **Written**

Summary of comment: There is no necessity for this requirement and the standard is unclear. This section would result in added costs for insurers with no benefit for consumers.

Response to comment: The commissioner considered the comment and rejects it. Refer to response to PIF.

Comments Re: SECTION 2695.7(s)

Comment No.: 13
Section: 2695.7(s)
Commentator: PIF, G. Diane Colborn
Date of Comment: 5/7/02
Type of Comment: Written and Oral

Summary of Comment: The proposed regulation imposes unnecessary and impractical burdens on insurance companies. Furthermore, the language is unclear in its intent and application to other data base systems such as DMV, NAIC and more.

Response to Comment: The commissioner has considered the comment, accepts it in part and rejects it in part. The language in the subsection holds insurers responsible for the data used to evaluate claims, as the insurer holds a superior position during the claims settlement process. The commissioner agrees, however, that insurers should not be responsible for data contained in government databases.

To clarify that only data used to value the claim is subject to this regulation, the following modification is proposed:

> **Insurers are responsible for the accuracy of data used to establish the value of insurance claims. Insurers choosing to use data from a computerized database source or any other source remains responsible for the accuracy of the data they use, whether this data is derived in-house or through third parties. Data which cannot be supported as accurate shall not be used in evaluating and settling insurance claims.**
>
> **(1) Insurers shall not be responsible for the accuracy of data provided by any governmental entity, unless it has discovered or been notified of the inaccuracy and has continued to use the data.**

Comment No.: 23
Section: 2695.7(s)
Commentator: Carol P. LaPlant Esq.
Date of Comment: 5/9/02
Type of Comment: Written

Summary of Comment: The proposed language is tremendously important to ensure that insurers remain responsible for the accuracy of computer data used in the evaluation of a claim even though the law does not allow an insurer to delegate its duty of good faith when settling the claims of its insureds. However, if there is a genuine concern about insurers being responsible for public data, the following language is submitted for consideration:

"Insurers choosing to use data from a commercial computerized data base source or any other commercial source…"

Response to Comment: The commissioner has considered the comment and accepts it in part and rejects it in part. While the commentator's language will not be adopted per se, modifications to the proposed subsection shall be made to address the concerns raised. To clarify that only data used to value the claim is subject to this regulation, new language has been proposed. See response to PIF comments.

Comment No.: **27**
Section: **2695.7(s)**
Commentator: **Alliance of American Insurers, Kirk Hansen**
Date of Comment: **5/9/02**
Type of Comment: **Written & E-mail**

Summary of Comment: It is unreasonable to require insurers to be responsible for the accuracy of computerized data used to evaluate insurance claims. Insurers do not have control over the data used by police departments, DMV, etc.

Response to Comment: The commissioner has considered the comment and accepts it in part and rejects it in part. See response to PIF.

Comment No.: **31**
Section: **2695.7(s)**
Commentator: **Ingenix, Eileen Shannon**
Date of Comment: **5/9/02**
Type of comment: **Written**

Summary of comment: The regulation is vague with respect to the terms "data" and "accuracy". These terms are not defined and therefore subject to interpretation. The vagueness of the regulation does not give sufficient guidance on how to determine whether data is accurate. We propose that accuracy be defined as conformance to the methodologies and documents describing the database – i.e. the data is accurate if it is a true and complete copy of the data that the database purports to contain. Disclosure of proprietary information to the Department so that such information would become public, should not be required. Additionally, the term data should be defined as "pricing or payment data" to distinguish it from clinical data.

Response to comment: The commissioner has considered the comment and accepts it in part and rejects it in part. To attempt to define "data" and "accuracy" is unnecessary and may cause too narrow an interpretation for the purposes of this regulation. The proposed language of the regulation is purposely broad to include all data used by an insurer to determine the "value" of a claim and the commissioner has proposed language to add clarity to the regulation. See response to PIF.

Comment No.: **22**
Section: **2695.7(s)**
Commentator: **National Insurance Crime Bureau (NICB), David A. De Young**
Date of comment: **5/8/02**
Type of comment: **Written**

1. Summary of Comment: It is unreasonable and burdensome to require insurers to be responsible for the accuracy of computerized data used to evaluate insurance claims. Insurers do not have control over the data maintained by governmental entities.

Response to Comment: The commissioner has considered the comment and accepts it in part and rejects it in part. See response to PIF.

2. Summary of comment: A strict interpretation of this regulation would actually require insurers to be responsible for the accuracy of information provided by one of their own policyholders.

Response to comment: The commissioner considered the comment and rejects it. The proposed language intends to hold insurers responsible for the accuracy of data used to value claims no matter where it comes from, including the insured. However, nothing in the proposed language excuses an insurer from its responsibility to investigate and report suspected fraud. The commissioner also recognizes an insurer's need to conduct the claims investigation process as efficiently as practical. To this end, if an insurer simply accepts data received from its insured to pay the claim without actually investigating the accuracy of such data, such acts are not prohibited by this regulation nor is the insurer necessarily in violation of any statutory claims handling requirements by accepting such data.

3. Summary of comment: Placing such burdens on insurers hinders their efforts to investigate and report suspected fraud. This subsection should be revised to allow insurers to use whatever credible sources are available when investigating suspected cases of insurance fraud.

Response to comment: The commissioner considered the comment and rejects it. Nothing in the proposed language precludes an insurer from exercising its duty to investigate and report suspected fraud. There is no need to change the language.

Comment No.: **18**
Section: **2695.7(s)**
Commentator: **National Association of Independent Insurers, Sam Sorich**
Date of comment: **5/8/02**
Type of comment: **Written and Oral**

1. **Summary of comment:** The proposed subsection is unreasonable because it would make an insurer responsible for the accuracy of erroneous information submitted by the claimant.

Response to comment: The commissioner considered the comment and rejects it. The proposed language intends to hold insurers responsible for the accuracy of data used to value claims no matter where it comes from. However, this subsection does not prohibit an insurer from paying claims based on unverified data such as estimates and receipts submitted by claimants.

2. **Summary of comment:** The proposed section is unreasonable because claims investigation includes reliance on motor vehicle records, claim databases, medical reports, medical evaluation guidelines and a number of other data sources. While these may be credible

sources of information, an insurer cannot prove the accuracy of every item of information in the database.

Response to summary: The commissioner considered the comment and accepts it in part and rejects it in part. See response to PIF.

3. Summary of comment: The imposition of the responsibility for accuracy of any data which is used to settle a claim would make it impossible for an insurer to carry out its duty to investigate fraud. There is no statutory authority for the imposition of this responsibility on insurers.

Response to comment: The commissioner considered the comment and rejects it. Nothing in the proposed language precludes an insurer from exercising its duty to investigate and report suspected fraud. Further, it is well established that the commissioner has the authority to promulgate regulations as respects claims settlement practices. The proposed language is in keeping with that authority.

Comment No.: 28
Section: 2695.7(s)
Commentator: CSAA, Douglas A. Lutgen
Date of comment: 5/9/02
Type of comment: Written

Summary of comment: Proposed language is unreasonable, unauthorized and inconsistent with statutes and regulations, preventing insurers from providing consumers with efficient, prompt and economical claims services. Refers to NAII comments.

Response to comment: The commissioner considered the comment and accepts it in part and rejects it in part. See response to NAII and PIF.

Comment No.: 35
Section: 2695.7(s)
Commentator: 21st Century Insurance Company, Barger & Wolen LLP, Kent R. Keller
Date of comment: 5/7/02
Type of comment: Written & Oral

1. Summary of comment: The Act does not authorize this amendment, which suggests a strict liability standard for accuracy of data.

Response to comment: The commissioner considered the comment and rejects it. The commentator provides no authority for such interpretation. The commissioner does not find that the accompanying regulations to the underlying Act suggests a "strict" liability standard.

2. Summary of comment: The duty of insurers to verify data is unclear.

Response to comment: The commissioner considered the comment and rejects it. See response to Ingenix and PIF.

3. **Summary of comment:** This amendment would set the adjustment process back decades and would cause substantial cost increases and inefficiencies. Insurers, as well as other types of companies, government agencies and individuals, regularly use data base information compiled by third parties such as DMV, Police Department Records, Department of Insurance etc.

Response to comment: The commissioner considered the comment and accepts it in part and rejects it in part. New language will be added to clarify that insurers are not responsible for data contained in government databases. See response to PIF.

4. **Summary of comment:** Insureds who dispute valuations are free to present evidence to the contrary or invoke the appraisal provision.

Response to comment: The commissioner considered the comment and accepts it. Nothing in the proposed language precludes an insured from either presenting further evidence concerning the value of a claim or invoking the appraisal process. The purpose of this subsection, is simply to hold insurers responsible for the accuracy of the data used by them to establish the value of insurance claims and to eliminate data that cannot be supported as accurate.

Comment No.: **37**
Section: **2695.7(s)**
Commentator: **Farmers Insurance Group, Bennett L. Katz**
Date of Comment: **5/14/02**
Type of Comment: **Written**

Summary of comment: Proposed language is not reasonable necessary to effectuate the purpose of the statute and is extremely burdensome and impossible to comply with for an insurer. The regulation should hold insurers to a good faith standard with respect to securing accuracy statements from third party vendors along with documented evidence supporting its statements for data provided by third party vendors.

Response to comment: The commissioner considered the comment and rejects it. See response to PIF.

Comment No.: **29**
Section: **2695.7(s)**
Commentator: **State Farm Insurance Companies, Steve McManus**
Date of comment: **5/9/02**
Type of comment: **Written**

Summary of comment: The subsection imposes a standard that is impossible for insurers to comply with. The subsection will only promote litigation for the benefit of contingency fee lawyers. Further this broad standard clearly does not have statutory authorization and will significantly slow the claims settlement process. With specific reference to computer databases, the language will deny consumers the benefits of costs savings and service efficiencies provided by technology.

Response to comment: The commissioner considered the comment and rejects it. See response to PIF.

Comment No.: **11**
Section: **2695.7(s)**
Commentator: **Association of California Insurance Companies, Jeffrey J. Fuller**
Date of comment: **5/7/02**
Type of comment: **Written and Oral**

Summary of comment: To hold insurers responsible for the accuracy of data used in the claims process is patently beyond the realm of reason. For example, there is no way and insurer can verify the data of the DMV. There is also no reason for them to do so. This requirement could "cut both ways" in that data submitted by claimants in support of a claim could not be relied upon by the insurer in evaluating the claim absent independent verification.

Response to comment: The commissioner considered the comment and accepts in part and rejects in part. The language will be amended to exclude data obtained from governmental agencies. See response to PIF.

Comment No.: **20**
Section: **2695.7(s)**
Commentator: **Mitchell International**
Date of comment: **May 8, 2002**
Type of comment: **Written**

Summary of comment: The proposed language is vague and subject to broad and varied interpretation. It will increase the cost of processing and settling claims and it could result in increased premium levels for California policyholders. The language clearly places the burden on carriers to independently verify the accuracy of the source data used by the third party data providers, arguably, on every claim.

Response to comment: The commissioner considered the comment and rejects it. See response to PIF.

Comments Re: Section 2695.8(b)

Comment No.: **13**
Section: **2695.8(b)**
Commentator: G. Diane Colborn, Personal Insurance Federation of California (PIFC)
Date of Comment: May 7, 2002
Type of Comment: Written Document Accompanying Oral Testimony

Summary of Comment: The proposed amendments to section 2695.8(b) include deletion of the term "first party" making the provisions relating to total loss valuations and replacement vehicles applicable to third party claims. This change is without authority since insurers have no contractual obligation to provide replacement vehicles to third parties.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it. The proposed amendment to this subsection does not require insurers to provide replacement vehicles to third parties. The only subsection that references replacement vehicles,

proposed section 2695.8(b)(4), specifically applies only to first party claims. However, section 2695.8(b), as proposed to be amended, does require that insurers value a total loss vehicle the same whether the claim is first or third party. Under an auto liability policy, the insurer is required to pay what the insured is legally liable for. California Civil Code Section 3333 states:

> 3333. For the breach of an obligation not arising from contract, the measure of damages, except where otherwise expressly provided by this Code, is the amount which will compensate for all the detriment proximately caused thereby, whether it could have been anticipated or not.

In third party automobile liability cases, this civil code section has been applied to require the negligent party to pay the injured party the cost to purchase an automobile of the same make, model, year, and condition as the totaled vehicle. This is the same standard currently used in valuing first party automobile claims. The proposed amendment to 2695.8(b) is necessary and clarifies the standard of valuing a totaled vehicle. The value of an automobile should not be different depending on whether the claimant made a claim against his/her insurer or the negligent party's insurer. Some insurers value third party claims differently than first party and attempt to provide lower settlement values to third parties.

Comment No.: **29**
Section: **2695.8(b)**
Commentator: Steve McManus, State Farm Insurance Companies
Date of Comment: May 9, 2002
Type of Comment: Written Document

Summary of Comment: The changes proposed to this subsection would expand current regulations to include third-party total loss claims. This change is not statutorily authorized as auto insurers are not contractually obligated to provide replacement vehicles to third parties. This proposed change is confusing and lacking clarity because settlement of first party claims are based upon contract, while settlement of third-party claims are based upon tort law.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it. The proposed amendment to this subsection does not require insurers to provide replacement vehicles to third parties. The only subsection that references replacement vehicles, 2695.8(b)(4), specifically applies only to first party claims. However, section 2695.8(b), as proposed to be amended, does require that insurers value a total loss vehicle the same whether the claim is first or third party. Under an auto liability policy, the insurer is required to pay what the insured is legally liable for. California Civil Code Section 3333 states:

> 3333. For the breach of an obligation not arising from contract, the measure of damages, except where otherwise expressly provided by this Code, is the amount which will compensate for all the detriment proximately caused thereby, whether it could have been anticipated or not.

In third party automobile liability cases, this civil code section has been applied to require the negligent party to pay the injured party the cost to purchase an automobile of the same make, model, year, and condition as the totaled vehicle. This is the same standard currently used in valuing first party automobile claims. The proposed amendment to 2695.8(b) is necessary and clarifies the standard of valuing a totaled vehicle and provides the Department with specific

regulations that can be charged against an insurer that pays less than the standard. The value of an automobile should not be different depending on whether the claimant made a claim against his/her insurer or the negligent party's insurer. Some insurers value third party claims differently than first party and attempt to provide lower settlement values to third parties.

Comment No.: **35**
Section: **2695.8(b)**
Commentator: Barger & Wolen LLP for 21st Century Insurance Company
Date of Comment: May 7, 2002
Type of Comment: Written Document

Summary of Comment: These amendments lack authority and are inconsistent with the Act in that they mandate coverage benefits. Also, the amendment violates basic concepts of indemnity in requiring sales tax to be paid for owner-retained salvage. The amendment also improperly imposes a tax in contravention of the California Constitution.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it. The proposed amendment to this subsection is within the authority of the commissioner, as it sets forth the reasonable procedure for settling automobile insurance claims. When an insured does not retain the loss vehicle and it is given over to the insurer, the actual cash value of the loss vehicle is measured based upon the value of that vehicle just prior to the loss. This actual cash value contains within it several components; (1) cash price, (2) sales tax, (3) license fees, and (4) other fees. The same components of actual cash value are present and sales tax is payable when an insured does retain the loss vehicle.

Also, this regulation does not impose a tax as suggested by the commentator. The regulation requires the liability insurer to pay the damaged third party the amount it would cost to purchase a vehicle comparable to the damaged vehicle, such amount includes the sales tax required to be paid when purchasing the vehicle. This is in accord with Civil Code Section 3333.

Subsection 2695.8(b)(1)

Comment No.: **11**
Section: **2695.8(b)(1)**
Commentator: Jeffrey J. Fuller, Association of California Insurance Companies (ACIC)
Date of Comment: May 7, 2002
Type of Comment: Written Document Accompanying Oral Testimony

Summary of Comment: An insurer should not be required to pay license fees, taxes, and other annual fees where the claimant elects to keep the vehicle. Moreover, there is no reason that this section should be expanded to apply to third party claimants who have no contractual relationship with the insurer.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it. When an insured does not retain the loss vehicle and it is given over to the insurer, the actual cash value of the loss vehicle is measured based upon the value of that vehicle just prior to the loss. This actual cash value contains within it several components; (1) cash price, (2) sales

tax, (3) license fees, and (4) other fees. The same components of actual cash value are present and sales tax is payable when an insured does retain the loss vehicle.

Also, Section 2695.8(b), as proposed to be amended, requires that insurers value a total loss vehicle the same whether the claim is first or third party. California Civil Code Section 3333 states:

> 3333. For the breach of an obligation not arising from contract, the measure of damages, except where otherwise expressly provided by this Code, is the amount which will compensate for all the detriment proximately caused thereby, whether it could have been anticipated or not.

In third party automobile liability cases, this civil code section has been applied to require the negligent party to pay the injured party the cost to purchase an automobile of the same make, model, year, and condition as the totaled vehicle. This is the same standard currently used in valuing first party automobile claims. The proposed amendment to 2695.8(b) is necessary and clarifies the standard of valuing a totaled vehicle and provides the Department with specific regulations that can be charged against an insurer that pays less than the standard. The value of an automobile should not be different depending on whether the claimant made a claim against his/her insurer or the negligent party's insurer. Some insurers value third party claims differently than first party and attempt to provide lower settlement values to third parties.

Also, this subsection does not require payment of license fees and other annual fees where the claimant elects to keep the vehicle. However, it does require the insurer to pay the prorated portion of sales tax, as described in proposed section 2695.8(b)(1)(A).

Comment No.: **4**
Section: **2695.8(b)(1)**
Commentator: John Metz
Date of Comment: April 24, 2002
Type of Comment: Written Document

Summary of Comment: Since the purpose of this insurance coverage is to put the claimant back in the condition the claimant was in before the loss, there is neither logic nor fairness in permitting the insurer to shift these burdens or limit its payment to claimants by this device. Moreover, there appears to be no logic in permitting a lesser standard in third party claims, where liability is reasonably clear, since the goal of the replacement in those situations is substantially the same. Our Financial Responsibility laws were enacted primarily to protect those harmed by first party insureds.

Response to Comment: The Commissioner has considered the commentator's suggestion and accepts it in part and rejects it in part. The Department's proposed changes to this subsection does resolve the inequity described by the commentator. Therefore, the commentator's suggested changes are not necessary.

Subsection 2695.8(b)(1)(A)

Comment No.: **29**
Section: **2695.8(b)(1)(A)**
Commentator: Steve McManus, State Farm Insurance Companies
Date of Comment: May 9, 2002
Type of Comment: Written Document

Summary of Comment: What is CDI's intention with respect to the new requirement that insurers provide contact information for the salvage dealer? Is this intended to give claimants an opportunity to change their mind and sell the salvage vehicle? Or is it intended to allow the claimant to verify the salvage deduction? The intent should be clarified.

Response to Comment: The Commissioner has considered the commentator's suggestion and responds as follows: The purpose of the amendment to this subsection is two-fold: (1) to allow the claimant to verify the salvage bid to determine the accuracy of the deduction and (2) to allow the claimant to determine whether the salvage vehicle should be retained by the claimant, relinquished to the insurer (in first party claims), or sold to the salvage dealer.

Comment No.: **36**
Section: **2695.8(b)(1)(A)**
Commentator: Kent Keller, Barger & Wolen
Date of Comment: May 9, 2002
Type of Comment: Written Document of Oral Testimony

Summary of Comment: This regulation improves policy terms by regulatory fiat.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it. The proposed amendments to section 2695.8(b)(1)(A) do not expand an insurer's obligation in paying total loss claims and do not improve policy terms. The regulation as currently in force does not allow an insurer to withhold sales tax when the insured retains the loss vehicle and/or the insured otherwise does not replace the loss vehicle. These proposals merely intend to clarify the Commissioner's current position on this issue and to correct the inconsistency among insurers in settling total loss claims in California.

As described in section 2695.8(b)(1), the calculation of the settlement amount is not based upon whether the insured does, or does not, replace the damaged vehicle. This subsection describes the components which make up the value of the loss vehicle for settlement purposes. This method of settlement (including sales tax and fees in payment of actual cash value claims) is a standard practice in the industry and was in place prior to the original 1993 effective date of these regulations. When an insured does not retain the loss vehicle and it is given over to the insurer, the actual cash value of the loss vehicle is measured based upon the value of that vehicle just prior to the loss. This actual cash value contains within it several components; (1) cash price, (2) sales tax, (3) license fees, and (4) other fees.

In reference to section 2695.8(b)(1)(A), the same components of actual cash value are present and sales tax is payable when an insured does retain the loss vehicle.

Comment No.: **28**
Section: **2695.8(b)(1)(A)**

Commentator: Douglas A. Lutgen, CSAA Inter-Insurance Bureau
Date of Comment: May 9, 2002
Type of Comment: Written Document

Summary of Comments: The "licensed salvage dealer" requirement impermissibly and without statutory authority specifies a particular subgroup of an industry with which insurers must deal in determining salvage value. It grants to one specified type of business the special and exclusive right to deal with insurers. A greater breadth of choice should be allowed to include the "amount of a guaranteed bid for the salvage obtained from a salvage pool or licensed wholesale motor vehicle auction" or "the amount of an appraisal obtained from a salvage pool or licensed wholesale motor vehicle auction where such appraisal is derived from historical regional auction data for the salvage of the same year, make model, and damage type."

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it in part and accepts it in part. The commissioner acknowledges that a greater choice should be allowed to include other entities that purchase, sell or otherwise deal with salvage vehicles for insurers. However, the commentator's proposed language is overly broad. The entity that determines the salvage value must be required to stand behind that value by purchasing the salvage should the claimant wish to sell. This subsection will be amended to allow greater choice as follows:

(A) If the insured chooses to retain the loss vehicle or if the third party claimant retains the loss vehicle, the cash settlement amount shall include the sales tax associated with the cost of a comparable automobile, discounted by the amount of sales tax attributed to the salvage value of the loss vehicle. The cash settlement amount shall also include all fees incident to transfer of the claimant's vehicle to salvage status. The salvage value may be deducted from the settlement amount and shall be determined by the amount for which a salvage pool or a licensed salvage dealer, wholesale motor vehicle auction or dismantler will purchase the salvage. If requested by the claimant, the insurer shall provide the name, address and telephone number of the salvage dealer, salvage pool, motor vehicle auction or dismantler who will purchase the salvage. The insurer shall disclose in writing to the claimant that notice of the salvage retention by the claimant must be provided to the Department of Motor Vehicles and that this notice may affect the loss vehicle's future resale and/or insured value. The disclosure must also inform the claimant of his or her right to seek a refund of the unused license fees from the Department of Motor Vehicles.

Comment No.: **18**
Section: **2695.8(b)(1)(A)**
Commentator: Samuel Sorich, National Association of Independent Insurers
Date of Comment: May 8, 2002
Type of Comment: Written Document

Summary of Comments: The proposed subsection would require the insurer to pay the sale tax associated with the cost of a comparable automobile when the insured chooses to retain the total loss vehicle. The Department provides no justification or authority for this provision. Requiring payment of sales tax to a person who chooses to keep the loss vehicle would result in betterment rather than fair compensation to the claimant.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it. The regulations as currently in force do not allow an insurer to withhold sales tax when the insured retains the loss vehicle and/or the insured otherwise does not replace the loss vehicle. These proposals merely intend to clarify the Commissioner's current position on this issue and to correct the inconsistency among insurers in settling total loss claims in California.

As described in section 2695.8(b)(1), the calculation of the settlement amount is not based upon whether the insured does, or does not, replace the damaged vehicle. This subsection describes the components which make up the value of the loss vehicle for settlement purposes. This method of settlement (including sales tax and fees in payment of actual cash value claims) is a standard practice in the industry and was in place prior to the original 1993 effective date of these regulations. When an insured does not retain the loss vehicle and it is given over to the insurer, the actual cash value of the loss vehicle is measured based upon the value of that vehicle just prior to the loss. This actual cash value contains within it several components; (1) cash price, (2) sales tax, (3) license fees, and (4) other fees. In reference to section 2695.8(b)(1)(A), the same components of actual cash value are present and sales tax is payable when an insured does retain the loss vehicle.

Comment No.: **35**
Section: **2695.8(b)(1)(A)**
Commentator: Barger & Wolen LLP for 21st Century Insurance Company
Date of Comment: May 7, 2002
Type of Comment: Written Document

Summary of Comment: These amendments lack authority and are inconsistent with the Act in that they mandate coverage benefits. Also, the amendment violates basic concepts of indemnity in requiring sales tax to be paid for owner-retained salvage. The amendment also improperly imposes a tax in contravention of the California Constitution.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it. The regulation is consistent with the Unfair Practices Act, does not violate the basic concepts of indemnity and does not impose a tax. The regulations as currently in force do not allow an insurer to withhold sales tax when the insured retains the loss vehicle and/or the insured otherwise does not replace the loss vehicle. These proposals merely intend to clarify the Commissioner's current position on this issue and to correct the inconsistency among insurers in settling total loss claims in California.

As described in section 2695.8(b)(1), the calculation of the settlement amount is not based upon whether the insured does, or does not, replace the damaged vehicle. This subsection describes the components which make up the value of the loss vehicle for settlement purposes. This method of settlement (including sales tax and fees in payment of actual cash value claims) is a standard practice in the industry and was in place prior to the original 1993 effective date of these regulations. When an insured does not retain the loss vehicle and it is given over to the insurer, the actual cash value of the loss vehicle is measured based upon the value of that vehicle just prior to the loss. This actual cash value contains within it several components; (1) cash price, (2) sales tax, (3) license fees, and (4) other fees. In reference to section 2695.8(b)(1)(A), the same components of actual cash value are present and sales tax is payable when an insured does retain the loss vehicle.

Comment No.: **4**
Section: **2695.8(b)(1)(A)**
Commentator: John Metz
Date of Comment: April 24, 2002
Type of Comment: Written Document

Summary of Comments: The Commentator suggests that this subsection be changed to require the salvage value deduction be supported by a binding offer from the salvage dealer. This change is necessary to ensure that the salvage value included in the insurer's offer is based on the actual market value at the time the settlement is concluded and the claimant receives the money. It is only the real market value at the time the settlement is concluded, and the claimant has money-in-hand to act, that truly reflects the amount of the benefit owed by the insurer and that to which the claimant is entitled. Any deviation inflicts a needless injustice on the claimant, the insured, other policyholders, insurer shareholders or all of them. It results in either over or under payment and unfair competition.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it in part and accepts it in part. The commissioner acknowledges that the entity that determines the salvage value must be required to stand behind that value by purchasing the salvage should the claimant wish to sell. However, the commissioner also acknowledges, based upon other comments received, that a greater choice should be allowed to include other entities that purchase, sell or otherwise deal with salvage vehicles for insurers. The commentator's proposed language is too restrictive. This subsection will be amended as follows:

(A) If the insured chooses to retain the loss vehicle or if the third party claimant retains the loss vehicle, the cash settlement amount shall include the sales tax associated with the cost of a comparable automobile, discounted by the amount of sales tax attributed to the salvage value of the loss vehicle. The cash settlement amount shall also include all fees incident to transfer of the claimant's vehicle to salvage status. The salvage value may be deducted from the settlement amount and shall be determined by the amount for which a salvage pool or a licensed salvage dealer, wholesale motor vehicle auction or dismantler will purchase the salvage. If requested by the claimant, the insurer shall provide the name, address and telephone number of the salvage dealer, salvage pool, motor vehicle auction or dismantler who will purchase the salvage. The insurer shall disclose in writing to the claimant that notice of the salvage retention by the claimant must be provided to the Department of Motor Vehicles and that this notice may affect the loss vehicle's future resale and/or insured value. The disclosure must also inform the claimant of his or her right to seek a refund of the unused license fees from the Department of Motor Vehicles.

Subsection 2695.8(b)(2)

Comment No.: **23**
Section: **2695.8(b)(2)**
Commentator: Carol P. La Plant, Attorney at Law
Date of Comment: May 9, 2002
Type of Comment: Written Document Accompanying Oral Testimony

Summary of Comments: Section 2695.8 provides greatly needed clarification as to the meaning of "comparable vehicle" in valuing total loss claims and make the price of a comparable vehicle verifiable and objective. This amendment contains standards that are implicit in the current regulations but have been ignored or misinterpreted by insurers. Clarity in regard to the meaning of comparable vehicle is a powerful means of preventing future abuse. Restrictions on the use of new model comparables, with deductions, is warranted because the amounts of such deductions are arbitrary and unverifiable, and the practice of using newer model vehicles seems to serve as an excuse for presenting an unverifiable, unfairly low valuation. The specification that the cost of a comparable vehicle is appropriate and extremely necessary, because such prices reflect the actual price of a replacement vehicle. There has been tremendous abuse in regard to the fabrication and distortion of comparable vehicle price data. The specification that conditions adjustments that cannot be supported shall not be used is appropriate and necessary, because the dollar amounts of condition adjustments have traditionally been based on estimates rather than objectively verifiable price data. The clarification that condition adjustments should only be deducted when valuing below average vehicles is consistent with the present regulations, but speaks to an area of consistent abuse by the insurance industry. Condition adjustments in the valuation of average condition vehicles are unfair because the condition of the comparable automobiles has not been inspected. The requirement that comparable vehicles be identified specifically is very helpful to ensure the accuracy of price data.

Response: The Commissioner agrees with the statements made by the commentator. However, the commissioner does recognize the concerns of the industry on the issue of the level of specific information required to identify a comparable vehicle. The proposed amendment will be changed to allow the insurer to identify the VIN and license plate number "if this information is available." If not available, the insurer may provide the telephone number or street address of the private party selling the vehicle. This addresses the concern of the commentator.

Comment No.: **13**
Section: **2695.8(b)(2)**
Commentator: G. Diane Colborn, Personal Insurance Federation of California (PIFC)
Date of Comment: May 7, 2002
Type of Comment: Written Document Accompanying Oral Testimony

Summary of Comments: Several changes are proposed to the definition of "comparable automobile" that would have the effect of reducing the accuracy and statistical reliability of valuations, and in some cases over-inflating the values produced. Those changes include:

1. Limitation on the use of newer model year vehicles - This limitation would reduce the number of potential comparable vehicles, diminishing the statistical validity of the valuations.

Response: The Commissioner has considered the commentator's suggestion and rejects it. This amendment would not diminish the statistical validity of the valuations. An insurer is only prohibited from using newer model year vehicles if there are a sufficient number of same model year vehicles to formulate a statistically valid value. In most cases when a newer model year vehicle is used as a comparable vehicle, it is accompanied by a significant deduction based upon its newer model year. While the Commissioner may agree that a newer model year vehicle may be worth more that a same model year vehicle, it is the extent of this monetary difference which is concerning. In many cases the amount deducted for this newer model year cannot be supported. Our experience has been that insurers will prefer to use newer models, even when

there are plenty of same model year vehicles, in order to capitalize upon the large deduction taken. For this reason, when there are sufficient vehicles of the same model year, these same model year vehicles should be utilized. However, when a sufficient number of same model year vehicles are not available, newer model year vehicles may be used as long as any deductions based upon this difference are adequately supported and documented.

2. Requiring use of the asking price on non-sold cars--This would eliminate the use of take prices, and artificially inflate the values.

Response: The Commissioner has considered the commentator's suggestion and rejects it. This subsection does not require the use of asking price. It permits the use of actual sales prices of the vehicle, which is the most accurate reflection of the market. Use of the ask-price would only be an issue if the insurer or its representative chooses not to use sales prices. The purpose of the regulations is to preclude the use of a "take-price". The take-price methodology used by computerized automobile valuation companies results in unsupportable undervaluing of the vehicle. The take-price is used by these companies to represent what they contend is a more accurate reflection of the actual sell price of a particular vehicle. The basic assumption here is that the "ask price" is negotiated down during the sales process. However, the CDI's investigation of consumer complaints and market conduct examinations shows that the take price of a comparable vehicle is based upon what the dealer would take in an all-cash purchase for that vehicle and is the lowest possible price a consumer could pay for that vehicle if he/she was a skilled negotiator. The standard for valuing an automobile for purposes of paying insurance claims should not be lowest possible price a consumer could pay for a car. The value should be based upon what an average consumer, with average negotiating skills, would pay.

Further, our investigation shows that in cases where an actual sales price is known, the take price used was lower than what the vehicle sold for. This supports our contention that take-prices are artificially low.

3. Limiting deduction for the condition of the loss vehicle - This would appear to require that all loss vehicles be valued at dealer ready prices, which will also result in artificially inflated valuations.

Response: The Commissioner has considered the commentator's suggestion and rejects it. The proposed amendment would not require that all loss vehicles be valued at dealer ready prices. The regulations require that the settlement amount be the <u>average</u> cost of a comparable vehicle. Therefore, the value derived is an average value, not a dealer ready value. The proposed regulations permit a condition deduction if the loss vehicle is <u>below average</u>, however, many companies deduct for condition even when the loss vehicle is in <u>average</u> condition. The CDI has conducted an exhaustive investigation into the use of a condition deduction. We have determined that applying a condition deduction when the loss vehicle is in average condition is unsupportable and creates unreasonably low settlement amounts to claimants. This proposal does not prohibit the use of a condition deduction, but permits one where the loss vehicle is in below average condition.

4. Requirement for VIN or license number identification--This requirement would eliminate the ability to use most private party ads and would reduce the pool of comparable vehicles.

Response: The Commissioner has considered the commentator's suggestion and accepts it. The proposed amendment will be changed to allow the insurer to identify the VIN and license plate number "if this information is available." If not available, the insurer may provide the telephone number or street address of the private party selling the vehicle. This addresses the concern of the commentator.

Comment No.: **28**
Section: **2695.8(b)(2)**
Commentator: Douglas A. Lutgen, CSAA Inter-Insurance Bureau
Date of Comment: May 9, 2002
Type of Comment: Written Document

Summary of Comment: We share industry concerns regarding the relative unavailability of VIN number/license plate information on privately-advertised vehicles, and the unrealistic nature of using an asking price that is almost never paid by automobile purchasers.

Response: The Commissioner has considered the commentator's suggestion and rejects it in part and accepts it in part. On the "ask price" comment, the take-price used by computerized automobile valuation companies result in unsupportable undervaluing of the vehicle. The take-price is used by these companies to represent what they contend are a more accurate reflection of the actual sell price of a particular vehicle. The basic assumption here is that the "ask price" is negotiated down during the sales process. However, the CDI's investigation of consumer complaints and market conduct examinations shows that the take price of a comparable vehicle used by certain valuation companies is based upon what the dealer would take in an all-cash purchase for that vehicle and is the lowest possible price a consumer could pay for that vehicle if he/she was a skilled negotiator. The standard for valuing an automobile for purposes of paying insurance claims should not be lowest possible price a consumer could pay for a car. The value should be based upon what an average consumer, with average negotiating skills, would pay.

Further, our investigation shows that in cases where an actual sales price is known, the take price used was lower than what the vehicle sold for. This supports our contention that take-prices are artificially low.

On the unavailability of VIN number/license plate information on private vehicles, the Commissioner has considered the commentator's suggestion and accepts it. The proposed amendment will be changed to allow the insurer to identify the VIN and license plate number "if this information is available." If not available, the insurer may provide the telephone number or street address of the private party selling the vehicle. This addresses the concern of the commentator.

Comment No.: **29**
Section: **2695.8(b)(2)**
Commentator: Steve McManus, State Farm Insurance Companies
Date of Comment: May 9, 2002
Type of Comment: Written Document

Summary of Comments: Several changes are proposed to the definition of "comparable automobile" that would have the effect of reducing the accuracy and statistical reliability of valuations, and in some cases over-inflating the values produced. Those changes include:

1. Limitation on the use of newer model year vehicles - This limitation would reduce the statistical validity of values given for comparable vehicles. Valuations would be less accurate.

Response: The Commissioner has considered the commentator's suggestion and rejects it. This amendment would not diminish the statistical validity of the valuations. An insurer is only prohibited from using newer model year vehicles if there are a sufficient number of same model year vehicles to formulate a statistically valid value. In most cases when a newer model year vehicle is used as a comparable vehicle, it is accompanied by a significant deduction based upon its newer model year. While the Commissioner may agree that a newer model year vehicle may be worth more that a same model year vehicle, it is the extent of this monetary difference which is concerning. In many cases the amount deducted for this newer model year cannot be supported. Our experience has been that insurers will prefer to use newer models, even when there are plenty of same model year vehicles, in order to capitalize upon the large deduction taken. For this reason, when there are sufficient vehicles of the same model year, these same model year vehicles should be utilized. However, when a sufficient number of same model year vehicles are not available, newer model year vehicles may be used as long as any deductions based upon this difference are adequately supported and documented.

2. Requiring use of the asking price on non-sold cars -This would eliminate the use of take prices, and artificially inflate the values. Requiring insurers to value total losses based upon asking price is requiring the overpayment of these claims.

Response: The Commissioner has considered the commentator's suggestion and rejects it. This subsection does not require the use of asking price. It permits the use of actual sales prices of the vehicle, which is the most accurate reflection of the market. Use of the ask-price would only be an issue if the insurer or its representative chooses not to use actual sales prices. The purpose of the regulations is to preclude the use of a "take-price". The take-price methodology used by computerized automobile valuation companies results in unsupportable undervaluing of the vehicle. The take-price is used by these companies to represent what they contend is a more accurate reflection of the actual sell price of a particular vehicle. The basic assumption here is that the "ask price" is negotiated down during the sales process. However, the CDI's investigation of consumer complaints and market conduct examinations shows that the take price of a comparable vehicle is based upon what the dealer would take in an all-cash purchase for that vehicle and is the lowest possible price a consumer could pay for that vehicle if he/she was a skilled negotiator. The standard for valuing an automobile for purposes of paying insurance claims should not be lowest possible price a consumer could pay for a car. The value should be based upon what an average consumer, with average negotiating skills, would pay.

Further, our investigation shows that in cases where an actual sales price is known, the take price used was lower than what the vehicle sold for. This supports our contention that take-prices are artificially low.

3. Limiting deduction for the condition of the loss vehicle - This requirement prohibits consideration of condition in many instances and will artificially inflate the condition and value of many vehicles.

Response: The Commissioner has considered the commentator's suggestion and rejects it. The proposed amendment would not require that all loss vehicles be valued at dealer ready prices and would not prohibit consideration of condition. The regulations require that the settlement amount be the average cost of a comparable vehicle. Therefore, the value derived is an average value, not a dealer ready value. The proposed regulations permit a condition deduction if the loss vehicle is below average, however, many companies deduct for condition even when the loss vehicle is in average condition. The CDI has conducted an exhaustive investigation into the use of a condition deduction. We have determined that applying a condition deduction when the loss vehicle is in average condition is unsupportable and creates unreasonably low settlement amounts to claimants. This proposal does not prohibit the use of a condition deduction, but permits one where the loss vehicle is in below average condition.

4. Requirement for VIN or license number identification--This requirement would eliminate the ability to use most private party ads and would reduce the pool of comparable vehicles.

Response: The Commissioner has considered the commentator's suggestion and accepts it. The proposed amendment will be changed to allow the insurer to identify the VIN and license plate number "if this information is available." If not available, the insurer may provide the telephone number or street address of the private party selling the vehicle. This addresses the concern of the commentator.

Comment No.: **6**
Section: **2695.8(b)(2)**
Commentator: John S. Benton, Government Strategies, Inc.
Date of Comment: May 4, 2002
Type of Comment: Written Document

Summary of Comment: Certain wording in this subsection may put ADP's consumer friendly product in jeopardy.

Response: The Commissioner has considered the commentator's suggestion and accepts it. The proposed amendment will be changed to allow the insurer to identify the VIN and license plate number "if this information is available." If not available, the insurer may provide the telephone number or street address of the private party selling the vehicle. This addresses the concern of the commentator.

Comment No.: **18**
Section: **2695.8(b)(2)**
Commentator: Samuel Sorich, National Association of Independent Insurers
Date of Comment: May 8, 2002
Type of Comment: Written Document

Summary of Comment: The proposed definition of "comparable automobile" is unnecessary and unreasonable. The definition would result in unfair settlements which do not reflect the real value of losses.

1. Requiring use of the asking price on non-sold cars -The commentator states that absolute reliance on the asking-price would give an unrealistic and inflated value to comparable automobiles.

Response: The Commissioner has considered the commentator's suggestion and rejects it. This subsection does not require the use of asking price. It permits the use of actual sales prices of the vehicle, which is the most accurate reflection of the market. Use of the ask-price would only be an issue if the insurer or its representative chooses not to use actual sales prices. The purpose of the regulations is to preclude the use of a "take-price". The take-price methodology used by computerized automobile valuation companies results in unsupportable undervaluing of the vehicle. The take-price is used by these companies to represent what they contend is a more accurate reflection of the actual sell price of a particular vehicle. The basic assumption here is that the "ask price" is negotiated down during the sales process. However, the CDI's investigation of consumer complaints and market conduct examinations shows that the take price of a comparable vehicle is based upon what the dealer would take in an all-cash purchase for that vehicle and is the lowest possible price a consumer could pay for that vehicle if he/she was a skilled negotiator. The standard for valuing an automobile for purposes of paying insurance claims should not be lowest possible price a consumer could pay for a car. The value should be based upon what an average consumer, with average negotiating skills, would pay.

Further, our investigation shows that in cases where an actual sales price is known, the take price used was lower than what the vehicle sold for. This supports our contention that take-prices are artificially low.

2. Requirement for VIN or license number identification - The commentator states that this requirement calls for a level of detailed information that is not necessary to determine the realistic value of a comparable vehicle.

Response: The Commissioner has considered the commentator's suggestion and accepts it. The proposed amendment will be changed to allow the insurer to identify the VIN and license plate number "if this information is available." If not available, the insurer may provide the telephone number or street address of the private party selling the vehicle. This addresses the concern of the commentator.

Comment No.: **38**
Section: **2695.8(b)(2)**
Commentator: Bill Gausewitz, American Insurance Association (AIA).
Date of Comment: May 9, 2002
Type of Comment: Written Document

Summary of Comment: This requirement effectively eliminates the use of private sales advertisements for calculating comparable vehicle value.

Response: The Commissioner has considered the commentator's suggestion and accepts it. The proposed amendment will be changed to allow the insurer to identify the VIN and license plate number "if this information is available." If not available, the insurer may provide the telephone number or street address of the private party selling the vehicle. This addresses the concern of the commentator.

Comment No.: **35**
Section: **2695.8(b)(2)**
Commentator: Barger & Wolen LLP for 21st Century Insurance Company
Date of Comment: May 7, 2002
Type of Comment: Written Document

Summary of Comments: The Department proposes significant amendments to this section, discussed below, which limit insurers' ability to evaluate total loss vehicles using comparable automobiles. Each of these amendments lacks authority, is inconsistent with the Act and is impractical. Those amendments include:

1. The use of newer model year vehicles - This commentator states that this amendment violates the standards of authority and consistency because section 790.03 does not address the insurer's methods of determining comparable automobiles for purposes of evaluating the loss.

Response: The Commissioner has considered the commentator's suggestion and rejects it. This amendment would not violate the standards of authority and consistency. California Insurance Code section 790.03(h)(5) makes it a violation of law for an insurer "not attempting in good faith, to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear." The commissioner has the authority to develop regulations which prohibit certain claims practices that would violate this statute. Also, an insurer is only prohibited from using newer model year vehicles if there are a sufficient number of same model year vehicles to formulate a statistically valid value. In most cases when a newer model year vehicle is used as a comparable vehicle, it is accompanied by a significant deduction based upon its newer model year. While the Commissioner may agree that a newer model year vehicle may be worth more that a same model year vehicle, it is the extent of this monetary difference which is concerning. In many cases the amount deducted for this newer model year cannot be supported. Our experience has been that insurers will prefer to use newer models, even when there are plenty of same model year vehicles, in order to capitalize upon the large deduction taken. For this reason, when there are sufficient vehicles of the same model year, these same model year vehicles should be utilized. However, when a sufficient number of same model year vehicles are not available, newer model year vehicles may be used as long as any deductions based upon this difference are adequately supported and documented.

2. Requiring use of the asking price -This commentator states that this amendment is impractical, as the asking price is an inaccurate measure of value, and would increase insurance costs.

Response: The Commissioner has considered the commentator's suggestion and rejects it. This subsection does not require the use of asking price. It permits the use of actual sales prices of the vehicle, which is the most accurate reflection of the market. Use of the ask-price would only be an issue if the insurer or its representative chooses not to use sales prices. The purpose of the regulations is to preclude the use of a "take-price". The take-price methodology used by computerized automobile valuation companies results in unsupportable undervaluing of the vehicle. The take-price is used by these companies to represent what they contend is a more accurate reflection of the actual sell price of a particular vehicle. The basic assumption here is that the "ask price" is negotiated down during the sales process. However, the CDI's investigation of consumer complaints and market conduct examinations shows that the take price of a comparable vehicle is based upon what the dealer would take in an all-cash purchase for that

vehicle and is the lowest possible price a consumer could pay for that vehicle if he/she was a skilled negotiator. The standard for valuing an automobile for purposes of paying insurance claims should not be lowest possible price a consumer could pay for a car. The value should be based upon what an average consumer, with average negotiating skills, would pay.

Further, our investigation shows that in cases where an actual sales price is known, the take price used was lower than what the vehicle sold for. This supports our contention that take-prices are artificially low.

3. Condition Adjustments - This commentator states that this amendment would restrict insurers to using comparable vehicles that are in the same condition as the loss vehicle, severely reducing the number of vehicles available.

Response: The Commissioner has considered the commentator's suggestion and rejects it. The proposed amendment would not restrict insurers to using comparable vehicles that are in the same condition as the loss vehicle and would not reduce the number of vehicles available. Under this regulation no comparable vehicle would be prohibited from inclusion in determining a vehicle value, it only prohibits the use of a condition adjustment deduction on those sample vehicles used that in are in the same condition as the loss vehicle. The regulations require that the settlement amount be the average cost of a comparable vehicle. Therefore, the value derived is an average value, not a dealer ready value. The proposed regulations permit a condition deduction if the loss vehicle is below average, however, many companies deduct for condition even when the loss vehicle is in average condition. The CDI has conducted an exhaustive investigation into the use of a condition deduction. We have determined that applying a condition deduction when the loss vehicle is in average condition is unsupportable and creates unreasonably low settlement amounts to claimants. This proposal does not prohibit the use of a condition deduction, but permits one where the loss vehicle is in below average condition.

Comment No.: **4**
Section: **2695.8(b)(2)**
Commentator: John Metz
Date of Comment: April 24, 2002
Type of Comment: Written Document

Summary of Comments: The Commentator suggests that this subsection be changed to require that the cost of a comparable automobile be calculated "at the time the claimant actually obtains the settlement funds from the insurer to which the claimant and the insurer have agreed". This change is necessary to ensure that the cost of a comparable automobile included in the insurer's offer is based on the actual market value at the time the settlement is concluded and the claimant receives the money.

Response: The Commissioner has considered the commentator's suggestion and rejects it. Such a standard would not be practical as it would require insurers to recalculate and find new comparable vehicles several times during the negotiation process. Further, the value of a total loss vehicle is its value at the time of the accident or insured event, not the time when the final settlement offer is made.

Comment No.: **34**

Section: **2695.8(b)(2)**
Commentator: Mark S. Mester, Latham & Watkins, for CCC Information Services, Inc.
Date of Comment: May 9, 2002
Type of Comment: Written Document

Summary of Comments: The commentator points out several concerns with the proposed definition of "comparable automobile" that would have the effect of reducing the accuracy and statistical reliability of valuations, and in some cases over-inflating the values produced. Those changes include:

1. Limitation on the use of newer model year vehicles - This limitation would result in less reliable and less accurate local market valuations.

Response: The Commissioner has considered the commentator's suggestion and rejects it. This amendment would not diminish the statistical validity of the valuations. An insurer is only prohibited from using newer model year vehicles if there are a sufficient number of same model year vehicles to formulate a statistically valid value. In most cases when a newer model year vehicle is used as a comparable vehicle, it is accompanied by a significant deduction based upon its newer model year. While the Commissioner may agree that a newer model year vehicle may be worth more that a same model year vehicle, it is the extent of this monetary difference which is concerning. In many cases the amount deducted for this newer model year cannot be supported. Our experience has been that insurers will prefer to use newer models, even when there are plenty of same model year vehicles, in order to capitalize upon the large deduction taken. For this reason, when there are sufficient vehicles of the same model year, these same model year vehicles should be utilized. However, when a sufficient number of same model year vehicles are not available, newer model year vehicles may be used as long as any deductions based upon this difference are adequately supported and documented.

2. Requiring use of the asking price on non-sold cars - The commentator suggests that this amendment would eliminate the use of take prices, which he believes are the mot accurate reflection of vehicle values.

Response: The Commissioner has considered the commentator's suggestion and rejects it. This subsection does not require the use of asking price. It permits the use of actual sales prices of the vehicle, which is the most accurate reflection of the market. Use of the ask-price would only be an issue if the insurer or its representative chooses not to use sales prices. The purpose of the regulations is to preclude the use of a "take-price". Contrary the commentator's opinion, the take-price is not the most accurate reflection of vehicle values, the actual sales price is the most accurate. The take-price methodology used by computerized automobile valuation companies results in unsupportable undervaluing of the vehicle. The take-price is used by these companies to represent what they contend is a more accurate reflection of the actual sell price of a particular vehicle. The basic assumption here is that the "ask price" is negotiated down during the sales process. However, the CDI's investigation of consumer complaints and market conduct examinations shows that the take price of a comparable vehicle is based upon what the dealer would take in an all-cash purchase for that vehicle and is the lowest possible price a consumer could pay for that vehicle if he/she was a skilled negotiator. The standard for valuing an automobile for purposes of paying insurance claims should not be lowest possible price a consumer could pay for a car. The value should be based upon what an average consumer, with average negotiating skills, would pay.

Further, our investigation shows that in cases where an actual sales price is known, the take price used was lower than what the vehicle sold for. This supports our contention that take-prices are artificially low.

3. Limiting deduction for the condition of the loss vehicle - The commentator suggests that this amendment prohibits the use of a condition adjustment and that this prohibition be deleted from the amendments. The commentator asserts that the average condition of vehicles on dealer lots is different that the average condition of privately advertised vehicles because of dealer prep and cleanup.

Response: The Commissioner has considered the commentator's suggestion and rejects it. The proposed amendment allows for a condition adjustment deduction when the loss vehicle is in worse condition than the comparable vehicles used to determine the value of the loss vehicle. The amendment does not prohibit a deduction if the value of a comparable automobile is determined solely by dealer vehicles, all those dealer vehicles have been inspected for condition and the verified condition of the dealer vehicles is superior to the verified condition of the loss vehicle. However, the regulations require that the settlement amount be the <u>average</u> cost of a comparable vehicle. Therefore, the value derived is an average value, not a dealer ready value, as asserted by the commentator. The proposed regulations permit a condition deduction if the loss vehicle is <u>below average</u>, however, many companies deduct for condition even when the loss vehicle is in <u>average</u> condition. The CDI has conducted an exhaustive investigation into the use of a condition deduction. We have determined that applying a condition deduction when the loss vehicle is in average condition is unsupportable and creates unreasonably low settlement amounts to claimants. This proposal does not prohibit the use of a condition deduction, but permits one where the loss vehicle is in below average condition.

Further, the condition adjustment method used by certain valuation companies has nothing to do with dealer prep or dealer cleanup. Certain vendors base the condition adjustment on alleged differences between the loss vehicle and the comparable vehicle (in terms of the engine, transmission, interior, paint and tires) that involve long term maintenance, long term exposure to elements or wear and tear, not dealer prep or clean up issues.

4. Requirement for VIN or license number identification The commentator suggests that this requirement would eliminate the ability to use most private party ads and would reduce the pool of comparable vehicles.

Response: The Commissioner has considered the commentator's suggestion and accepts it. The proposed amendment will be changed to allow the insurer to identify the VIN and license plate number "if this information is available." If not available, the insurer may provide the telephone number or street address of the private party selling the vehicle. This addresses the concern of the commentator.

<u>Subsection 2695.8(b)(2)(C)</u>

Comment No.: **4**
Section: **2695.8(b)(2)(C)**
Commentator: John Metz

Date of Comment: April 24, 2002
Type of Comment: Written Document

Summary of Comments: The Commentator suggests that this subsection be changed to require the actual cost of a comparable automobile be determined by "an independent and unbiased" computerized automobile valuation service "using the same parameters as those required when such a service is not used" that produces statistically valid fair market values within the local market area.

Response: The Commissioner has considered the commentator's suggestion and rejects it. The commentator's proposed language does not allow for the insurer performing its own computerized valuation, which is its right, as long as it is done reasonably and produces statistically valid results.

Subsection 2695.8(b)(2)(D)

Comment No.: **4**
Section: **2695.8(b)(2)(D)**
Commentator: John Metz
Date of Comment: April 24, 2002
Type of Comment: Written Document

Summary of Comments: The Commentator suggests that this subsection be changed to require the documentation used to determine the cost of a comparable automobile be supported by "verified" documentation.

Response: The Commissioner has considered the commentator's suggestion and rejects it. The term "verified" is vague, unnecessary and does not strengthen these regulations. The commissioner may currently require the insurer to provide sufficient evidence to support the validity and accuracy of any document submitted including those referenced in this subsection.

Subsection 2695.8(b)(3)

Comment No.: **23**
Section: **2695.8(b)(3)**
Commentator: Carol P. La Plant, Attorney at Law
Date of Comment: May 9, 2002
Type of Comment: Written Document Accompanying Oral Testimony

Summary of Comments: Section 2695.8(b)(3)(D) emphasizes the important restriction that deductions cannot be used unless they are supported. This restriction is necessary because deductions of arbitrary dollar amounts have been frequently used.

Response to Comment: The Commissioner agrees with the statements made by the commentator.

Comment No.: **13**
Section: **2695.8(b)(3)**

Commentator: G. Diane Colborn, Personal Insurance Federation of California (PIFC)
Date of Comment: May 7, 2002
Type of Comment: Written Document Accompanying Oral Testimony

Summary of Comment: This new section requires insurers to verify the accuracy of the determinations of the cost of the comparable vehicles. This would be a substantial burden on insurers.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it in part and accepts it in part. Section 2695.8(b)(3) describes the general obligation of an insurer when it calculates a vehicle value for settlement purposes. The insurer can appropriately be held responsible for the accuracy of the values it produces, or that are produced on its behalf. It should be noted that this language is not new. It is the identical language contained in the current regulations, section 2695.8(b)(1)(C). The commissioner does recognize the concerns of the industry, however, this regulation does not require the insurer to verify and recreate each valuation it obtains from a third party. The commissioner also has experienced difficulty in obtaining for review the evidence to support that insurers are reasonably valuing vehicles. The proposed amendment will be changed as follows:

(3) The insurer shall take reasonable steps to verify that the determination of the cost of a comparable vehicle is accurate and representative of the market value of a comparable automobile in the local market area. Upon its request, the department shall have access to all records, data, computer programs, or any other information used by the insurer or any other source to determine market value. The cost of a comparable automobile shall be determined as follows and, once determined, shall be fully itemized and explained in writing for the claimant at the time the settlement offer is made:

Comment No.: **29**
Section: **2695.8(b)(3)**
Commentator: Steve McManus, State Farm Insurance Companies
Date of Comment: May 9, 2002
Type of Comment: Written Document

Summary of Comment: We question the necessity of requiring insurer claim personnel to search dealer lots and newspaper ads to validate each individual comparable vehicle valuation. It would also be an impossible performance standard. This subsection needs to be clarified or reconsidered.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it in part and accepts it in part. Section 2695.8(b)(3) describes the general obligation of an insurer when it calculates a vehicle value for settlement purposes. The insurer is responsible for the accuracy of the values it produces, or that are produced on its behalf. It should be noted that this language is not new. It is the identical language contained in the current regulations, section 2695.8(b)(1)(C). The commissioner does recognize the concerns of the industry, however, this regulation does not require the insurer to verify and recreate each valuation it obtains from a third party. The commissioner also has experienced difficulty in obtaining for review the evidence to support that insurers are reasonably evaluating vehicles. The proposed amendment will be changed as follows:

(3) The insurer shall take reasonable steps to verify that the determination of the cost of a comparable vehicle is accurate and representative of the market value of a comparable automobile in the local market area. Upon its request, the department shall have access to all records, data, computer programs, or any other information used by the insurer or any other source to determine market value. The cost of a comparable automobile shall be determined as follows and, once determined, shall be fully itemized and explained in writing for the claimant at the time the settlement offer is made:

Comment No.: **24**
Section: **2695.8(b)(3)**
Commentator: Kirk Hansen, Alliance of American Insurers
Date of Comment: May 9, 2002
Type of Comment: Written Document

Summary of Comment: Regarding the steps outlined in Section 2695.8 for determining the value of a "comparable automobile", the regulations are too restrictive. Obtaining a quote may be difficult in some cases.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it. These proposed amendments are not restrictive. Valuation of an automobile by quotation is only one of several options available to an insurer in determining the cost of a comparable automobile. Further, proposed subsection 2695.8(b)(3)(D) provides an insurer with the ability to determine the value in any reasonable manner, if the prior three options are not appropriate for evaluating a particular automobile.

Comment No.: **35**
Section: **2695.8(b)(3)**
Commentator: Barger & Wolen LLP for 21st Century Insurance Company
Date of Comment: May 7, 2002
Type of Comment: Written Document

Summary of Comment: This commentator states that there is no requirement that insurers take particular steps to verify comparable vehicle data. The amendment is ambiguous, as it does not clarify insurers' verification duty. Insurers are entitled to use any available evidence to evaluate the claim. The insured may dispute the amount, provide contrary evidence or invoke the appraisal provision of the policy.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it in part and accepts it in part. Section 2695.8(b)(3) describes the general obligation of an insurer when it calculates a vehicle value for settlement purposes. The insurer can appropriately be held responsible for the accuracy of the values it produces, or that are produced on its behalf. However, it should be noted that this language is not new. It is the identical language contained in the current regulations, section 2695.8(b)(1)(C). The commissioner does recognize the concerns of the industry, however, this regulation does not require the insurer to verify and recreate each valuation it obtains from a third party. The commissioner also has experienced difficulty in obtaining for review the evidence to support that insurers are reasonably valuing vehicles. The proposed amendment will be changed as follows:

(3) The insurer shall take reasonable steps to verify that the determination of the cost of a comparable vehicle is accurate and representative of the market value of a comparable automobile in the local market area. Upon its request, the department shall have access to all records, data, computer programs, or any other information used by the insurer or any other source to determine market value. The cost of a comparable automobile shall be determined as follows and, once determined, shall be fully itemized and explained in writing for the claimant at the time the settlement offer is made:

Comment No.: **34**
Section: **2695.8(b)(3)**
Commentator: Mark S. Mester, Latham & Watkins, for CCC Information Services, Inc.
Date of Comment: May 9, 2002
Type of Comment: Written Document

Summary of Comments: The commentator is concerned that the proposed language lacks sufficient clarity. The commentator interprets it to require insurers to recreate each valuation it obtains from a third party. Such a requirement would significantly lengthen the claims settlement process.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it in part and accepts it in part. Section 2695.8(b)(3) describes the general obligation of an insurer when it calculates a vehicle value for settlement purposes. The insurer can appropriately be held responsible for the accuracy of the values it produces, or that are produced on its behalf. However, it should be noted that this language is not new. It is the identical language contained in the current regulations, section 2695.8(b)(1)(C). The commissioner does recognize the concerns of the industry, however, this regulation does not require the insurer to verify and recreate each valuation it obtains from a third party. The commissioner also has experienced difficulty in obtaining for review the evidence to support that insurers are reasonably valuing vehicles. The proposed amendment will be changed as follows:

(3) The insurer shall take reasonable steps to verify that the determination of the cost of a comparable vehicle is accurate and representative of the market value of a comparable automobile in the local market area. Upon its request, the department shall have access to all records, data, computer programs, or any other information used by the insurer or any other source to determine market value. The cost of a comparable automobile shall be determined as follows and, once determined, shall be fully itemized and explained in writing for the claimant at the time the settlement offer is made:

Subsection 2695.8(b)(4)

Comment No.: **4**
Section: **2695.8(b)(4)**
Commentator: John Metz
Date of Comment: April 24, 2002
Type of Comment: Written Document

Summary of Comments: The Commentator suggests that this subsection be changed to require the replacement automobile must be available for inspection "not more than 15 miles or 30 minutes from" the insured's residence, as compared to a reasonable distance from the insured's residence, as currently written. This change is necessary to avoid needless confusion, harm to claimants and the opportunity for unfair competition. The proposed defined limits are consistent with similar provisions in the regulations adopted pursuant to the Knox-Keene Act [CCR 1300.51(d)H.(i)] relating to the geographic area in which health care service plans are required to have providers to service its enrollees' needs.

Response: The Commissioner has considered the commentator's suggestion and rejects it. The commentators proposed language is too restrictive and would result in less vehicles being offered to claimants for replacement. The Commissioner prefers the reasonable distance standard in the current regulation.

Subsection 2695.8(c)

Comment No.: **4**
Section: **2695.8(c)**
Commentator: John Metz
Date of Comment: April 24, 2002
Type of Comment: Written Document

Summary of Comments: Current regulations require the insurer to reopen its claim file and perform certain acts if the insured advises the insurer within 35 days of payment that he or she cannot purchase a comparable vehicle for the gross settlement amount. The Commentator suggests that this subsection be changed to 90 days. The Commentator also suggests amendments to subsections 2695.8(c)(3) and (4).

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it. This portion of this subsection describing the 35-day requirement has not been amended from current law. Thirty-five days is sufficient time for the claimant to determine whether he or she can or can not purchase a comparable automobile for the gross settlement amount. Also, subsections 2695.8(c)(3) and (4) were not the subject of these proposed amendments. Therefore, this comment is outside the scope of this process.

Comment No.: **23**
Section: **2695.8(c)**
Commentator: Carol P. La Plant, Attorney at Law
Date of Comment: May 9, 2002
Type of Comment: Written Document Accompanying Oral Testimony

Summary of Comments: Section 2695.8(c) requires the insurer to inform the claimant of his or her rights in the event the valuation proves to be too low to purchase a comparable replacement. This requirement would help to make sure that the consumer is aware of this self-help provision.

Response to Comment: The Commissioner agrees with the statements made by the commentator.

Subsection 2695.8(d)

Comment No.: **4**
Section: **2695.8(d)**
Commentator: John Metz
Date of Comment: April 24, 2002
Type of Comment: Written Document

Summary of Comments: The Commentator suggests amendments to subsections 2695.8(d).

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it. No amendments have been proposed to subsection 2695.8(d). Therefore, this comment is outside the scope of this process.

Subsection 2695.8(f)

Comment No.: **10**
Section: **2695.8(f)**
Commentator: Senator Jackie Speier, California State Senate
Date of Comment: May 7, 2002
Type of Comment: Written Document

Summary of Comment: The commentator questions why the word "direct" is struck. In letters reviewed from insurers to policyholders regarding choice of shops, the language used is directive in nature. Also, this section would be strengthened if it were clarified that written notice must be given after an accident has occurred, a time when the claimant has the greatest need to know his or her rights to choose a shop.

Response to Comment: The Commissioner has considered the commentator's suggestions and rejects it in part and accepts it in part. The term "direct" is ambiguous and can mean "to order or command with authority" (see Webster's New World Dictionary). While not the intent of the regulations, keeping the word "direct" in this subsection might be construed to permit an insurer to direct (or order) an insured to use a particular shop. This practice is prohibited under subsection (e), which states that no "insurer shall require that an automobile be repaired at a specific repair shop." Removing the word "direct" will not provide less protection for consumers, but ensure the right of the consumer to select the repair shop. Also, even a strong steering of the claimant to a body shop is considered suggesting or recommending, which triggers the disclosure requirements in subsection (f)(1)&(2).

In regards to the written notice required in subsection (f)(2), the commissioner agrees the notice should be provided to the claimant after the accident. While the Auto Body Repair Consumer Bill of Rights may be provided at different times, this is in addition to the written notice required by this subsection. The current and proposed regulations do require this written notice to be provided after the accident. In order for the claimant to be more adequately informed of his or her rights we propose the following amendment to this subsection as follows:

(f) No insurer shall ~~(2) direct,~~ suggest or recommend that an automobile be repaired at a specific repair shop, unless,

(1) ~~(A)~~ such referral is expressly requested by the claimant; or,

(2) ~~(B)~~ the claimant has been informed in writing of the right to select the repair facility~~;~~ and~~,~~

~~(C)~~ the insurer ~~that elects to repair a vehicle or directs, suggests or recommends that a specific repair shop be used,~~ shall cause the damaged vehicle to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy or as otherwise allowed by these regulations. **If the recommendation of a repair shop is done orally, the insurer shall provide the information contained in this subsection, as noted in the statement below, to the claimant at the time the recommendation is made. The insurer shall send the written notice required by this subsection within five (5) calendar days from the oral recommendation. The written notice required by this subsection shall include the following statement plainly printed in no less than ten-point type:**

> **WE ARE PROHIBITED BY LAW FROM REQUIRING THAT REPAIRS BE DONE AT A SPECIFIC REPAIR SHOP. YOU ARE ENTITLED TO SELECT THE AUTO BODY REPAIR SHOP TO REPAIR DAMAGE COVERED BY US. WE HAVE RECOMMENDED A REPAIR SHOP THAT WILL REPAIR YOUR DAMAGED VEHICLE. AS YOU HAVE AGREED TO USE OUR RECOMMENDED REPAIR SHOP, WE WILL CAUSE THE DAMAGED VEHICLE TO BE RESTORED TO ITS CONDITION PRIOR TO THE LOSS AT NO ADDITIONAL COST TO YOU OTHER THAN AS STATED IN THE INSURANCE POLICY OR AS OTHERWISE ALLOWED BY LAW. IF YOU EXPERIENCE A PROBLEM WITH THE REPAIR OF YOUR VEHICLE, PLEASE CONTACT US IMMEDIATELY FOR ASSISTANCE.**

Comment No.: **3**
Section: **2695.8(f)**
Commentator: Jack T. Molodanof, for the California Autobody Association (CAA)
Date of Comment: April 7, 2002
Type of Comment: Written Document

Summary of Comment: Removing the word "direct" may weaken the regulations. Also, an additional subsection should be adopted to prevent illegal "steering" and "word tracking".

Response to Comment: The Commissioner has considered the commentator's suggestions and rejects them. The term "direct" is ambiguous and can mean "to order or command with authority" (see Webster's New World Dictionary). While not the intent of the regulations, keeping the word "direct" in this subsection might be construed to permit an insurer to direct (order) an insured to use a particular shop. This practice is prohibited under subsection (e), which states that no "insurer shall require that an automobile be repaired at a specific repair shop." Removing the word "direct" will not provide less protection for consumers, but ensure the right to select the repair shop. Also, even a strong steering of the claimant to a body shop is considered suggesting or recommending, which triggers the disclosure requirements in subsection (f)(1)&(2).

Subsection 2695.8(g)

Comment No.: **13**
Section: **2695.8(g)**
Commentator: G. Diane Colborn, Personal Insurance Federation of California (PIFC)
Date of Comment: May 7, 2002
Type of Comment: Written Document Accompanying Oral Testimony

Summary of Comment: This amendment would prohibit an insurer from discounting repair costs if the claimant elects to have the vehicle repaired at a shop other than that recommended by the insurer. This amendment has the effect of prohibiting insurers from offering PPO policy options for auto body repair. The effect will be to increase prices overall for auto insurance consumers.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it. The intent and the result of this proposed amendment will not increase costs to consumers. Current regulations prohibit an insurer from requiring the claimant to use a particular repair shop. However, an insurer may recommend a repair shop. Many insurers have direct repair programs where the insurer recommends the repair shop. However, 3-4 insurers in the non-standard market specifically direct the claimant to a repair shop. If the insured doesn't use that shop, he/she will be charged a substantial penalty. This is similar to the PPO concept in the health insurance market. If the insured goes to the PPO shop all that is paid is the deductible. If the insured goes outside the PPO network, the insured pays the deductible and a 20% co-payment penalty. These programs make up a negligible amount of the overall market, but do cater to the unsophisticated, usually non-English-speaking, consumer. A recent market conduct examination and review of consumers complaints with one particular insurer shows that the consumer is forced to pay for most of the repairs to the vehicle if he/she decides to go outside the PPO network. In the traditional PPO concept (in health) the cost of services is based upon the usual and customary charges in that area. If the person goes outside the PPO, the insurer will only pay 80% of the usual and customary charges. Unlike the health PPO, some automobile insurers place in their contracts a provision that states that the insurer will only pay 80% of what one of their discounted PPO shops would charge, if it had repaired the vehicle. This is a hypothetical charge, since the PPO shop never does the repairs. Also, these PPO shops provide the insurer with substantial parts and labor discounts. In actuality, the insurer only pays about 60% of what it would cost to actually repair that vehicle. This creates an unfair surprise to the consumer (and a windfall to the insurer) since the policy implies it will pay 80% of the repair costs.

Section 2695.8(g)(2) as proposed is not meant to expand coverage beyond the amount that is reasonable and customary in the market to repair the vehicle. It is intended solely to prohibit an insured from being unfairly penalized when he/she chooses to have the vehicle repaired in an insured chosen shop. In this respect the commentator may misunderstand the issue. The insured may still be required to pay a co-payment penalty if he/she has the loss vehicle repaired in a non-PPO shop. However, the additional reduction by an insurer based upon a sub-market repair cost comes as an unfair surprise to the insured and is considered by the Commissioner as against public policy.

Comment No.: **36**
Section: **2695.8(g)**
Commentator: Kent Keller, Barger & Wolen

Date of Comment: May 9, 2002
Type of Comment: Written Document Accompanying Oral Testimony

Summary of Comment: This regulation improves policy terms by regulatory fiat.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it. Current regulations prohibit an insurer from requiring the claimant to use a particular repair shop. However, an insurer may recommend a repair shop. Many insurers have direct repair programs where the insurer recommends the repair shop. However, 3-4 insurers in the non-standard market specifically direct the claimant to a repair shop. If the insured doesn't use that shop, he/she will be charged a substantial penalty. This is similar to the PPO concept in the health insurance market. If the insured goes to the PPO shop all that is paid is the deductible. If the insured goes outside the PPO network, the insured pays the deductible and a 20% co-payment penalty. These programs make up a negligible amount of the overall market, but do cater to the unsophisticated, usually non-English-speaking, consumer. A recent market conduct examination and review of consumers complaints with one particular insurer shows that the consumer is forced to pay for most of the repairs to the vehicle if he/she decides to go outside the PPO network. In the traditional PPO concept (in health) the cost of services is based upon the usual and customary charges in that area. If the person goes outside the PPO, the insurer will only pay 80% of the usual and customary charges. Unlike the health PPO, some automobile insurers place in their contracts a provision that states that the insurer will only pay 80% of what one of their discounted PPO shops would charge, if it had repaired the vehicle. This is a hypothetical charge, since the PPO shop never does the repairs. Also, these PPO shops provide the insurer with substantial parts and labor discounts. In actuality, the insurer only pays about 60% of what it would cost to actually repair that vehicle. This creates an unfair surprise to the consumer (and a windfall to the insurer) since the policy implies it will pay 80% of the repair costs.

Section 2695.8(g)(2) as proposed is not meant to expand coverage beyond the amount that is reasonable and customary in the market to repair the vehicle. It is intended solely to prohibit an insured from being unfairly penalized when he/she chooses to have the vehicle repaired in an insured chosen shop. The insured may still be required to pay a co-payment penalty if he/she has the loss vehicle repaired in a non-PPO shop. However, the additional reduction by an insurer based upon a sub-market repair cost comes as an unfair surprise to the insured and is considered by the Commissioner as against public policy.

Comment No.: **18**
Section: **2695.8(g)**
Commentator: Samuel Sorich, National Association of Independent Insurers
Date of Comment: May 8, 2002
Type of Comment: Written Document

Summary of Comment: This amendment would prohibit an insurer from discounting repair costs if the claimant elects to have the vehicle repaired at a shop other than that recommended by the insurer. This amendment is unfair. The Department provides no justification or authority for blocking this cost-saving option from consumers.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it. The intent and the result of this proposed amendment will not block a cost-saving

option for consumers and will not result in increased repair costs for insurers. Current regulations prohibit an insurer from requiring the claimant to use a particular repair shop. However, an insurer may recommend a repair shop. Many insurers have direct repair programs where the insurer recommends the repair shop. However, 3-4 insurers in the non-standard market specifically direct the claimant to a repair shop. If the insured doesn't use that shop, he/she will be charged a substantial penalty. This is similar to the PPO concept in the health insurance market. If the insured goes to the PPO shop all that is paid is the deductible. If the insured goes outside the PPO network, the insured pays the deductible and a 20% co-payment penalty. These programs make up a negligible amount of the overall market, but do cater to the unsophisticated, usually non-English-speaking, consumer. A recent market conduct examination and review of consumers complaints with one particular insurer shows that the consumer is forced to pay for most of the repairs to the vehicle if he/she decides to go outside the PPO network. In the traditional PPO concept (in health) the cost of services is based upon the usual and customary charges in that area. If the person goes outside the PPO, the insurer will only pay 80% of the usual and customary charges. Unlike the health PPO, some automobile insurers place in their contracts a provision that states that the insurer will only pay 80% of what one of their discounted PPO shops would charge, if it had repaired the vehicle. This is a hypothetical charge, since the PPO shop never does the repairs. Also, these PPO shops provide the insurer with substantial parts and labor discounts. In actuality, the insurer only pays about 60% of what it would cost to actually repair that vehicle. This creates an unfair surprise to the consumer (and a windfall to the insurer) since the policy implies it will pay 80% of the repair costs.

Section 2695.8(g)(2) as proposed is not meant to expand coverage beyond the amount that is reasonable and customary in the market to repair the vehicle. It is intended solely to prohibit an insured from being unfairly penalized when he/she chooses to have the vehicle repaired in an insured chosen shop. In this respect the commentator may misunderstand the issue. The insured may still be required to pay a co-payment penalty if he/she has the loss vehicle repaired in a non-PPO shop. However, the additional reduction by an insurer based upon a sub-market repair cost comes as an unfair surprise to the insured and is considered by the Commissioner as against public policy.

Subsection 2695.8(h)

Comment No.: **4**
Section: **2695.8(h)**
Commentator: John Metz
Date of Comment: April 24, 2002
Type of Comment: Written Document

Summary of Comments: The Commentator suggests amendments to subsections 2695.8(h) and would require the "unreasonable distance" standard be changed to "travel more than 15 miles or 30 minutes from the claimant's home".

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it. No substantive changes have been proposed to subsection 2695.8(h). Therefore, this comment is outside the scope of this process. However, the commissioner believes the reasonable distance standard is more appropriate.

Subsection 2695.8(i)

Comment No.: **10**
Section: **2695.8(i)**
Commentator: Senator Jackie Speier, California State Senate
Date of Comment: May 7, 2002
Type of Comment: Written Document

Summary of Comment: Subsection (i) touches upon the disclosure information that the commentator would like a policyholder to receive. The commentator suggests that language be added that would require the insurer to disclose the labor rate to be paid for the repair of a vehicle at a shop recommended by the insurer and the insurer who states that it will guarantee the work must, at the same time, disclose that other shops may guarantee the work as well.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it in part and accepts it in part. Requiring the insurer to disclose the labor rate paid for the repair is not in itself a claim practice and would not fall within the scope and authority for these regulations. Legislation would be more appropriate to resolve this concern. In reference to the work guarantee, we have proposed amendments to subsection 2695.8(f) as noted above that addresses much of this concern.

Comment No.: **13**
Section: **2695.8(i)**
Commentator: G. Diane Colborn, Personal Insurance Federation of California (PIFC)
Date of Comment: May 7, 2002
Type of Comment: Written Document Accompanying Oral Testimony

Summary of Comment: This amendment mandates that insurers must pay no less than the prevailing rates for auto body repairs. Free market competition is a more appropriate and efficient regulator of auto body shop prices.

Response to Comment: The Commissioner has considered the commentator's suggestion and accepts it. This subsection will be edited to delete the language in proposed section 2695.8(i) that refers to the "prevailing rate."

Comment No.: **29**
Section: **2695.8(i)**
Commentator: Steve McManus, State Farm Insurance Companies
Date of Comment: May 9, 2002
Type of Comment: Written Document

Summary of Comment: This amendment mandates that insurers must pay no less than the prevailing rates for auto body repairs. This provision lack statutory authority.

Response to Comment: The Commissioner has considered the commentator's suggestion and accepts it. This subsection will be edited to delete the language in section 2695.8(i) that refers to the "prevailing rate."

Comment No.: **11**
Section: **2695.8(i)**
Commentator: Jeffrey J. Fuller, Association of California Insurance Companies (ACIC)
Date of Comment: May 7, 2002
Type of Comment: Written Document Accompanying Oral Testimony

Summary of Comment: There is no valid purpose served by setting minimum rates insurers must pay to have vehicles repaired. Where repairs can be accomplished in a workmanlike manner for less money, the saving inures to the benefit of insurers and insurance consumers alike.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it in part and accepts it in part. We will delete the language in section 2695.8(i) that refers to the "prevailing rate."

Comment No.: **28**
Section: **2695.8(i)**
Commentator: Douglas A. Lutgen, CSAA Inter-Insurance Bureau
Date of Comment: May 9, 2002
Type of Comment: Written Document

Summary of Comment: There is no statutory authority for the regulations to require how much an insurer must pay for automobile labor rates, much less to establish or pay prevailing rates.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it in part and accepts it in part. We will delete the language in section 2695.8(i) that refers to the "prevailing rate."

Comment No.: **18**
Section: **2695.8(i)**
Commentator: Samuel Sorich, National Association of Independent Insurers
Date of Comment: May 8, 2002
Type of Comment: Written Document

Summary of Comment: The subsection amendment requiring payment of the "prevailing rate" would prohibit an insurer from writing an estimate at less than a prevailing rate, even if the shop does not typically charge this rate. There is no statutory authority for this amendment.

Response to Comment: The Commissioner has considered the commentator's suggestion and accepts it in part. We will delete the language in section 2695.8(i) that refers to the "prevailing rate."

Comment No.: **35**
Section: **2695.8(i)**
Commentator: Barger & Wolen LLP for 21st Century Insurance Company
Date of Comment: May 7, 2002
Type of Comment: Written Document

Summary of Comment: The subsection amendment requiring payment of the "prevailing rate" rewrites policy provisions contrary to the Department's authority. The amendment also would promote anti-competitive behavior and would increase costs. There would also be significant uncertainty over the level of prevailing rates and the boundaries of the local market areas.

Response to Comment: The Commissioner has considered the commentator's suggestion and accepts it in part. While the commissioner does have the statutory authority to set a standard of claim valuation that will result in reasonable claims settlements, the Department agrees with the problems associated with the use of "prevailing rates". The language in section 2695.8(i) that refers to the "prevailing rate" will be deleted.

Comment No.: **4**
Section: **2695.8(i)**
Commentator: John Metz
Date of Comment: April 24, 2002
Type of Comment: Written Document

Summary of Comments: The Commentator suggests amendments to subsections 2695.8(i) and would require that if partial losses are settled on the basis of a written estimate prepared by or for the insurer, the insurer shall supply the claimant with a copy of the estimate upon which the settlement is based **sufficiently before the date on which the settlement is finalized to permit the claimant to review and evaluate its accuracy**. The estimate prepared by or for the insurer shall be ~~in accordance with applicable policy provisions, and~~ of an amount which will allow for repairs to be made in a workmanlike manner **and which restores the loss vehicle to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy or as otherwise allowed by these regulations** and shall be no less than the prevailing rates charged in the claimant's local market area.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it. The commentator's proposal is not necessary and overburdensome on insurers. If the written estimate is not agreed to by the claimant there exists other options in this same subsection to resolve disputes.

Subsection 2695.8(i)(2)

Comment No.: **11**
Section: **2695.8(i)(2)**
Commentator: Jeffrey J. Fuller, Association of California Insurance Companies (ACIC)
Date of Comment: May 7, 2002
Type of Comment: Written Document Accompanying Oral Testimony

Summary of Comment: Most claimants have not read these regulations so they will not know to ask for a recommendation on repair shops. Insurers should be allowed to make recommendations as a means to providing service to their policyholders. The average policyholder/claimant has no familiarity with auto-body repair shops and appreciates the assistance offered by insurers in that regard. The term "restored" implies that the insurer must "renew" the vehicle or in some fashion return the vehicle to its previous value: Use of the term 'repair" would more accurately describe the insurer's obligation under the policy.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it. The language of this subsection is revised to clarify that when there is a dispute as to the cost of repairs and the insurer names a repair shop that can make the repairs for the amount of the insurer's written estimate, the insurer shall "cause the damaged vehicle to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy or as otherwise allowed by these regulations." This added language mirrors the requirement set forth in proposed section 2695.8(f) when an insurer suggests or recommends a repair shop and does not increase the insurer's obligation more than under current law. Further, this subsection does not limit an insurer's right to recommend a repair shop. Under proposed section 2695.8(f), the insurer may recommend a repair shop.

Comment No.: **37**
Section: **2695.8(i)(2)**
Commentator: Bennett L. Katz, Farmers Insurance Group
Date of Comment: May 14, 2002
Type of Comment: Written Document

Summary of Comment: The commentator objects to this section based upon a lack of necessity. The commentator also feels that this amendment opens the door for diminished value claims.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it. This subsection does not open the door for diminished value claims. The standard of repair and indemnity has not changed from current regulations, as noted above. The language of this subsection is revised to clarify that when there is a dispute as to the cost of repairs and the insurer names a repair shop that can make the repairs for the amount of the insurer's written estimate, the insurer shall "cause the damaged vehicle to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy or as otherwise allowed by these regulations." This added language mirrors the requirement set forth in proposed section 2695.8(f) when an insurer suggests or recommends a repair shop and does not increase the insurer's obligation more than under current law.

Comment No.: **28**
Section: **2695.8(i)(2)**
Commentator: Douglas A. Lutgen, CSAA Inter-Insurance Bureau
Date of Comment: May 9, 2002
Type of Comment: Written Document

Summary of Comment: The introductory phrase "if requested by the claimant" has been added. By virtue of this proposed change, an insurer could no longer voluntarily provide a claimant with the identity of a repair shop that will perform repairs for the amount of the insurer's estimate.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it. Section 2695.8(i)(2) as proposed and as currently written contains the "if requested by the claimant" language. An insurer under the current regulation is precluded from voluntarily providing a claimant with the identity of a repair shop that will perform repairs for the amount of the insurer's estimate in an effort to reduce the payment to the insured. No substantive change has been made on this issue. Therefore, this comment is outside the scope of this process.

However, it should be noted that this subsection does not preclude an insurer from recommending a repair shop to its insured as long as it is done in compliance with subsection 2695.8(f). Subsection 2695.8(i)(2) only applies when the insured and insurer do not agree as to the cost of making the necessary repairs and the insurer attempts to reduce the insured's estimate.

Comment No.: **35**
Section: **2695.8(i)(2)**
Commentator: Barger & Wolen LLP for 21st Century Insurance Company
Date of Comment: May 7, 2002
Type of Comment: Written Document

Summary of Comment: This amendment is inconsistent with the standard set forth in governing case law. In *Owens v. Pyeatt* (1967) 248 Cal.App.2d 840, 849, the Court stated that the standard of repair under the policy was "such that as would place the automobile in substantially the same condition it was before the accident." (Emphasis added). The commentator also cites *Ray v. Farmers Insurance exchange* (1988) 200 Cal.App.3d 1411, 1417 as its support that diminished value claims are not covered under California law.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it. The proposed amendment does not alter current case law on whether diminished value claims are covered. The proposed language of this subsection only clarifies that when there is a dispute as to the cost of repairs and the insurer names a repair shop that can make the repairs for the amount of the insurer's written estimate, the insurer shall "cause the damaged vehicle to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy or as otherwise allowed by these regulations." This added language mirrors the requirement set forth in proposed section 2695.8(f) when an insurer suggests or recommends a repair shop and does not increase the insurer's obligation more than under current law.

Comment No.: **4**
Section: **2695.8(i)(2)**
Commentator: John Metz
Date of Comment: April 24, 2002
Type of Comment: Written Document

Summary of Comments: The Commentator suggests amendments to subsections 2695.8(i)(2) that would clarify that the repair shop will make the repairs for the amount of the **"insurer's"** written estimate and the insurer shall maintain **"verified"** documentation of all communications.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it in part and accepts it in part. The commissioner agrees that it is appropriate to clarify that the repair shop will make the repairs for the amount of the **"insurer's"** written estimate, and will propose adding **"insurer's"** to this subsection. However, the adding the term "verified" is vague and not necessary. The Department will examine any documentation for its accuracy and determine whether such documentation sufficiently supports the required communications.

Subsection 2695.8(i)(3)

Comment No.: **4**
Section: **2695.8(i)(3)**
Commentator: John Metz
Date of Comment: April 24, 2002
Type of Comment: Written Document

Summary of Comments: The Commentator suggests amendments to subsections 2695.8(i)(3) that would require the insurer to "**cause the damaged vehicle to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy or as otherwise allowed by these regulations"** when the insurer reasonably adjusts any written estimates prepared by the repair shop of the claimant's choice.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it. The commentator's proposed language is impractical as the insurer does not have control over the repair process when the claimant chooses the shop to effect repairs. The insurer should only be held to the proposed standard when it recommends the shop that effects repairs.

Comments RE: Subsection 2695.8(j)

Comment No.: **4**
Section: **2695.8(j)**
Commentator: John Metz
Date of Comment: April 24, 2002
Type of Comment: Written Document

Summary of Comments: The Commentator suggests amendments to subsections 2695.8(j)(1) and (3) by adding the word "appearance" to the standards for using an aftermarket replacement crash part.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it. No changes have been proposed to subsections 2695.8(j)(1) and (3). Therefore, this comment is outside the scope of this process.

Comments RE: Subsection 2695.8(l)

Comment No.: **13**
Section: **2695.8(l)**
Commentator: G. Diane Colborn, Personal Insurance Federation of California (PIFC)
Date of Comment: May 7, 2002
Type of Comment: Written Document Accompanying Oral Testimony

Summary of Comment: The amendment to this section allows for the unjust enrichment to the claimant by limiting adjustments for betterment to only visible parts that are normally subject to repair and replacement. As example of betterment that could not be accounted for under this language is a previously dented fender that has been further damaged in the accident.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it in part and accepts it in part. First, betterment is not limited to "visible" parts as suggested by the commentator. This section permits an insurer to apply betterment to all parts. Second, it is not the intent of this amendment to prohibit an insurer from deducting, from its settlement, prior damage to the vehicle such as the previously dented fender. In order to provide greater clarity to this subsection, we propose the following change:

> Section 2695.8(l) to be amended (new language in bold): "**Except for prior and/or unrelated damage to the vehicle,** when the amount claimed is adjusted because of betterment or depreciation..."

Comment No.: **29**
Section: **2695.8(l)**
Commentator: Steve McManus, State Farm Insurance Companies
Date of Comment: May 9, 2002
Type of Comment: Written Document

Summary of Comment: The term "et cetera" lacks clarity, patently.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it. Section 2695.8(l)(2) is not the subject of these proposed amendments. Therefore, this comment is outside the scope of this process. Further, the comment is vague.

Subsection 2695.8(m)

Comment No.: **13**
Section: **2695.8(m)**
Commentator: G. Diane Colborn, Personal Insurance Federation of California (PIFC)
Date of Comment: May 7, 2002
Type of Comment: Written Document Accompanying Oral Testimony

Summary of Comment: This section seeks to mandate policy terms through regulation and is clearly outside the scope of the authority granted to the Department. This section as amended would mandate every insurer to pay reasonable towing and storage charges whether or not such coverage is provided under the policy. Some insurers may in fact offer towing services as a separate coverage.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it in part and accepts it in part. First, the commentator appears to be confusing towing services provided under a motor club coverage, like AAA, with reimbursement for towing charges incurred after a vehicle has been damaged in an accident. The intent of this section is to apply only to towing charges incurred after an accident or other covered loss (like a recovered theft).

Second, the Department is not mandating policy terms. All automobile insurance policies contain a clause that places an affirmative duty on the insured to protect the vehicle from further

loss. As an example, a certain major insurer places a duty upon the insured to ***"protect the damaged vehicle. We will pay any reasonable expense incurred to do it."*** Other insurers have a similar provision. Courts have consistently held that in the presence of such a clause, the insured may recover expenses including storage and towing costs incurred to protect the vehicle from further loss. (See Couch on Insurance, § 54:174; Appleman's §3885; and 7A Am Jur 2d § 424). It is currently industry practice to pay reasonable towing and storage charges as part of the standard automobile physical damage insurance coverage offered to insureds. However, some insurers will ignore this portion of the policy and deny or reduce claims for towing and storage expenses.

Further, as stated in 7A Am Jur 2d § 424, even in the absence of a "protection of property" clause, it has been held that an insured is entitled to reimbursement from the insurer for costs incurred in protecting against further loss after the insured vehicle has been in an accident. In this regard it has been said that, an insured must do everything reasonable to minimize the amount of the loss and that, having so minimized the loss, the insured is entitled to the amount expended by it for the benefit of the insurer.

The CDI is not mandating policy terms. The relevant policy terms already exist. When insureds purchase automobile coverage they have a reasonable expectation that certain minimum expenses will be covered in the event of a loss, such as towing and storage charges. The proposed amendment to 2695.8(m) sets forth the minimum claims standard in paying the reasonable towing and storage charges incurred in performing the duty to protect the vehicle, as supported by case law. CIC Section 790.03(h)(1) prohibits an insurer from misrepresenting insurance policy provisions relating to coverage. By denying or reducing claims for towing and storage (in the presence of the duty-to-protect clause) the insurer is misrepresenting its policy provisions.

Also, under an auto liability policy, the insurer is required to pay what the insured is legally liable for. California Civil Code Section 3333 states:

> 3333. For the breach of an obligation not arising from contract, the measure of damages, except where otherwise expressly provided by this Code, is the amount which will compensate for all the detriment proximately caused thereby, whether it could have been anticipated or not.

In third party automobile liability cases, this civil code section has been applied to require payment of reasonable towing and storage charges proximately caused by the negligent party.

In order to clarify the intent of this regulation, the Department proposes an edit to this section as follows:

(m) ~~(l) Every~~ **The** insurer shall **pay reasonable towing and storage charges incurred by the ~~claimant~~ insured and** provide reasonable notice to ~~a claimant~~ **the insured** before terminating payment for storage charges~~,~~ so that the ~~claimant~~ **insured** has time to remove the vehicle from storage. **Once liability has been determined, an insurer shall pay all reasonable towing and storage charges incurred by a third party claimant and provide reasonable notice to the claimant before terminating payment for storage charges so that the claimant has time to remove the vehicle from storage. The payment to a third party claimant may be prorated based upon the comparative fault of the parties involved.**

Comment No.: **11**
Section: **2695.8(m)**
Commentator: Jeffrey J. Fuller, Association of California Insurance Companies (ACIC)
Date of Comment: May 7, 2002
Type of Comment: Written Document Accompanying Oral Testimony

Summary of Comment: Not all insurance policies cover towing and storage charges, and there is no statute that requires that they do so. The department lacks the statutory authority to impose this requirement on insurers.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it in part and accepts it in part. All automobile insurance policies contain a clause that places an affirmative duty on the insured to protect the vehicle from further loss. As an example, a certain major insurer places a duty upon the insured to ***"protect the damaged vehicle. We will pay any reasonable expense incurred to do it."*** Other insurers have a similar provision. Courts have consistently held that in the presence of such a clause, the insured may recover expenses including storage and towing costs incurred to protect the vehicle from further loss. (See Couch on Insurance, § 54:174; Appleman's §3885; and 7A Am Jur 2d § 424). It is currently industry practice to pay reasonable towing and storage charges as part of the basic automobile physical damage insurance coverage offered to insureds. However, some insurers will ignore this portion of the policy and deny or reduce claims for towing and storage expenses.

Further, as stated in 7A Am Jur 2d § 424, even in the absence of a "protection of property" clause, it has been held that an insured is entitled to reimbursement from the insurer for costs incurred in protecting against further loss after the insured vehicle has been in an accident. In this regard it has been said that, an insured must do everything reasonable to minimize the amount of the loss and that, having so minimized the loss, the insured is entitled to the amount expended by it for the benefit of the insurer.

The CDI is not mandating policy terms. The relevant policy terms already exist. When insureds purchase automobile coverage they have a reasonable expectation that certain minimum expenses will be covered in the event of a loss, such as towing and storage charges. The proposed amendment to 2695.8(m) sets forth the minimum claims standard in paying the reasonable towing and storage charges incurred in performing the duty to protect the vehicle, as supported by case law. CIC Section 790.03(h)(1) prohibits an insurer from misrepresenting insurance policy provisions relating to coverage. By denying or reducing claims for towing and storage (in the presence of the duty-to-protect clause) the insurer is misrepresenting its policy provisions.

Also, under an auto liability policy, the insurer is required to pay what the insured is legally liable for. California Civil Code Section 3333 states:

> 3333. For the breach of an obligation not arising from contract, the measure of damages, except where otherwise expressly provided by this Code, is the amount which will compensate for all the detriment proximately caused thereby, whether it could have been anticipated or not.

In third party automobile liability cases, this civil code section has been applied to require payment of reasonable towing and storage charges proximately caused by the negligent party.

In order to clarify the intent of this regulation, the Department proposes an edit to this section as follows:

(m) ~~(l) Every~~ **The** insurer shall **pay reasonable towing and storage charges incurred by the ~~claimant~~ insured and** provide reasonable notice to ~~a claimant~~ **the insured** before terminating payment for storage charges~~,~~ so that the ~~claimant~~ **insured** has time to remove the vehicle from storage. **Once liability has been determined, an insurer shall pay all reasonable towing and storage charges incurred by a third party claimant and provide reasonable notice to the claimant before terminating payment for storage charges so that the claimant has time to remove the vehicle from storage. The payment to a third party claimant may be prorated based upon the comparative fault of the parties involved.**

Comment No.: **29**
Section: **2695.8(m)**
Commentator: Steve McManus, State Farm Insurance Companies
Date of Comment: May 9, 2002
Type of Comment: Written Document

Summary of Comment: The proposed language would require insurers to pay the towing and storage charges of a claimant on any claim. This requirement is not authorized by statute and it lacks clarity.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it in part and accepts it in part. The proposed language does not require payment of towing and storage charges of a claimant on any claim. All automobile insurance policies contain a clause that places an affirmative duty on the insured to protect the vehicle from further loss. As an example, a certain major insurer places a duty upon the insured to ***"protect the damaged vehicle. We will pay any reasonable expense incurred to do it."*** Other insurers have a similar provision. Courts have consistently held that in the presence of such a clause, the insured may recover expenses including storage and towing costs incurred to protect the vehicle from further loss. (See Couch on Insurance, § 54:174; Appleman's §3885; and 7A Am Jur 2d § 424). It is currently industry practice to pay reasonable towing and storage charges as part of the basic automobile physical damage insurance coverage offered to insureds. However, some insurers will ignore this portion of the policy and deny or reduce claims for towing and storage expenses.

Further, as stated in 7A Am Jur 2d § 424, even in the absence of a "protection of property" clause, it has been held that an insured is entitled to reimbursement from the insurer for costs incurred in protecting against further loss after the insured vehicle has been in an accident. In this regard it has been said that, an insured must do everything reasonable to minimize the amount of the loss and that, having so minimized the loss, the insured is entitled to the amount expended by it for the benefit of the insurer.

The CDI is not mandating policy terms. The relevant policy terms already exist. When insureds purchase automobile coverage they have a reasonable expectation that certain minimum expenses will be covered in the event of a loss, such as towing and storage charges. The proposed amendment to 2695.8(m) sets forth the minimum claims standard in paying the reasonable towing and storage charges incurred in performing the duty to protect the vehicle, as supported by case law. CIC Section 790.03(h)(1) prohibits an insurer from misrepresenting insurance policy provisions relating to coverage. By denying or reducing claims for towing and storage (in the presence of the duty-to-protect clause) the insurer is misrepresenting its policy provisions.

Also, under an auto liability policy, the insurer is required to pay what the insured is legally liable for. California Civil Code Section 3333 states:

> 3333. For the breach of an obligation not arising from contract, the measure of damages, except where otherwise expressly provided by this Code, is the amount which will compensate for all the detriment proximately caused thereby, whether it could have been anticipated or not.

In third party automobile liability cases, this civil code section has been applied to require payment of reasonable towing and storage charges proximately caused by the negligent party.

In order to clarify the intent of this regulation, the Department proposes an edit to this section as follows:

(m) ~~(l) Every~~ **The** insurer shall **pay reasonable towing and storage charges incurred by the ~~claimant~~ insured and** provide reasonable notice to ~~a claimant~~ **the insured** before terminating payment for storage charges~~,~~ so that the ~~claimant~~ **insured** has time to remove the vehicle from storage. **Once liability has been determined, an insurer shall pay all reasonable towing and storage charges incurred by a third party claimant and provide reasonable notice to the claimant before terminating payment for storage charges so that the claimant has time to remove the vehicle from storage. The payment to a third party claimant may be prorated based upon the comparative fault of the parties involved.**

Comment No.: **36**
Section: **2695.8(m)**
Commentator: Kent Keller, Barger & Wolen
Date of Comment: May 9, 2002
Type of Comment: Written Document Accompanying Oral Testimony

Summary of Comment: This regulation improves policy terms by regulatory fiat.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it in part and accepts it in part. The proposed language does not improve policy terms, but sets forth the minimum claims practices required to apply to current policy terms. All automobile insurance policies contain a clause that places an affirmative duty on the insured to protect the vehicle from further loss. As an example, a certain major insurer places a duty upon the insured to ***"protect the damaged vehicle. We will pay any reasonable expense incurred to do it."*** Other insurers have a similar provision. Courts have consistently held that in the

presence of such a clause, the insured may recover expenses including storage and towing costs incurred to protect the vehicle from further loss. (See Couch on Insurance, § 54:174; Appleman's §3885; and 7A Am Jur 2d § 424). It is currently industry practice to pay reasonable towing and storage charges as part of the basic automobile physical damage insurance coverage offered to insureds. However, some insurers will ignore this portion of the policy and deny or reduce claims for towing and storage expenses.

Further, as stated in 7A Am Jur 2d § 424, even in the absence of a "protection of property" clause, it has been held that an insured is entitled to reimbursement from the insurer for costs incurred in protecting against further loss after the insured vehicle has been in an accident. In this regard it has been said that, an insured must do everything reasonable to minimize the amount of the loss and that, having so minimized the loss, the insured is entitled to the amount expended by it for the benefit of the insurer.

The CDI is not mandating policy terms. The relevant policy terms already exist. When insureds purchase automobile coverage they have a reasonable expectation that certain minimum expenses will be covered in the event of a loss, such as towing and storage charges. The proposed amendment to 2695.8(m) sets forth the minimum claims standard in paying the reasonable towing and storage charges incurred in performing the duty to protect the vehicle, as supported by case law. CIC Section 790.03(h)(1) prohibits an insurer from misrepresenting insurance policy provisions relating to coverage. By denying or reducing claims for towing and storage (in the presence of the duty-to-protect clause) the insurer is misrepresenting its policy provisions.

Also, under an auto liability policy, the insurer is required to pay what the insured is legally liable for. California Civil Code Section 3333 states:

> 3333. For the breach of an obligation not arising from contract, the measure of damages, except where otherwise expressly provided by this Code, is the amount which will compensate for all the detriment proximately caused thereby, whether it could have been anticipated or not.

In third party automobile liability cases, this civil code section has been applied to require payment of reasonable towing and storage charges proximately caused by the negligent party.

In order to clarify the intent of this regulation, the Department proposes an edit to this section as follows:

(m) ~~(l) Every~~ **The** insurer shall **pay reasonable towing and storage charges incurred by the ~~claimant~~ insured and** provide reasonable notice to ~~a claimant~~ **the insured** before terminating payment for storage charges~~,~~ so that the ~~claimant~~ **insured** has time to remove the vehicle from storage. **Once liability has been determined, an insurer shall pay all reasonable towing and storage charges incurred by a third party claimant and provide reasonable notice to the claimant before terminating payment for storage charges so that the claimant has time to remove the vehicle from storage. The payment to a third party claimant may be prorated based upon the comparative fault of the parties involved.**

Comment No.: 28

Section: **2695.8(m)**
Commentator: Douglas A. Lutgen, CSAA Inter-Insurance Bureau
Date of Comment: May 9, 2002
Type of Comment: Written Document

Summary of Comment: This amendment is overly broad and is not supported by statutory authority. In addition, the proposed language would appear to require that towing and storage charges be paid even to third party claimants in situations where the insurer's insured has been determined to not be responsible for the damage to the claimant's vehicle.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it in part and accepts it in part. While broadly written, the intent of the proposed language is supported by statutory authority and case law. All automobile insurance policies contain a clause that places an affirmative duty on the insured to protect the vehicle from further loss. As an example, a certain major insurer places a duty upon the insured to ***"protect the damaged vehicle. We will pay any reasonable expense incurred to do it."*** Other insurers have a similar provision. Courts have consistently held that in the presence of such a clause, the insured may recover expenses including storage and towing costs incurred to protect the vehicle from further loss. (See Couch on Insurance, § 54:174; Appleman's §3885; and 7A Am Jur 2d § 424). It is currently industry practice to pay reasonable towing and storage charges as part of the standard automobile physical damage insurance coverage offered to insureds. However, some insurers will ignore this portion of the policy and deny or reduce claims for towing and storage expenses.

Further, as stated in 7A Am Jur 2d § 424, even in the absence of a "protection of property" clause, it has been held that an insured is entitled to reimbursement from the insurer for costs incurred in protecting against further loss after the insured vehicle has been in an accident. In this regard it has been said that, an insured must do everything reasonable to minimize the amount of the loss and that, having so minimized the loss, the insured is entitled to the amount expended by it for the benefit of the insurer.

The CDI is not mandating policy terms. The relevant policy terms already exist. When insureds purchase automobile coverage they have a reasonable expectation that certain minimum expenses will be covered in the event of a loss, such as towing and storage charges. The proposed amendment to 2695.8(m) sets forth the minimum claims standard in paying the reasonable towing and storage charges incurred in performing the duty to protect the vehicle, as supported by case law. CIC Section 790.03(h)(1) prohibits an insurer from misrepresenting insurance policy provisions relating to coverage. By denying or reducing claims for towing and storage (in the presence of the duty-to-protect clause) the insurer is misrepresenting its policy provisions.

Also, under an auto liability policy, the insurer is required to pay what the insured is legally liable for. California Civil Code Section 3333 states:

> 3333. For the breach of an obligation not arising from contract, the measure of damages, except where otherwise expressly provided by this Code, is the amount which will compensate for all the detriment proximately caused thereby, whether it could have been anticipated or not.

In third party automobile liability cases, this civil code section has been applied to require payment of reasonable towing and storage charges proximately caused by the negligent party.

In order to clarify the intent of this regulation, the Department proposes an edit to this section as follows:

(m) ~~(l) Every~~ **The** insurer shall **pay reasonable towing and storage charges incurred by the ~~claimant~~ insured and** provide reasonable notice to ~~a claimant~~ **the insured** before terminating payment for storage charges~~,~~ so that the ~~claimant~~ **insured** has time to remove the vehicle from storage. **Once liability has been determined, an insurer shall pay all reasonable towing and storage charges incurred by a third party claimant and provide reasonable notice to the claimant before terminating payment for storage charges so that the claimant has time to remove the vehicle from storage. The payment to a third party claimant may be prorated based upon the comparative fault of the parties involved.**

Comment No.: **18**
Section: **2695.8(m)**
Commentator: Samuel Sorich, National Association of Independent Insurers
Date of Comment: May 8, 2002
Type of Comment: Written Document

Summary of Comment: This amendment is too broad and is not supported by statutory authority.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it in part and accepts it in part. While broadly written, the intent of the proposed language is supported by statutory authority and case law. All automobile insurance policies contain a clause that places an affirmative duty on the insured to protect the vehicle from further loss. As an example, a certain major insurer places a duty upon the insured to ***"protect the damaged vehicle. We will pay any reasonable expense incurred to do it."*** Other insurers have a similar provision. Courts have consistently held that in the presence of such a clause, the insured may recover expenses including storage and towing costs incurred to protect the vehicle from further loss. (See Couch on Insurance, § 54:174; Appleman's §3885; and 7A Am Jur 2d § 424). It is currently industry practice to pay reasonable towing and storage charges as part of the standard automobile physical damage insurance coverage offered to insureds. However, some insurers will ignore this portion of the policy and deny or reduce claims for towing and storage expenses.

Further, as stated in 7A Am Jur 2d § 424, even in the absence of a "protection of property" clause, it has been held that an insured is entitled to reimbursement from the insurer for costs incurred in protecting against further loss after the insured vehicle has been in an accident. In this regard it has been said that, an insured must do everything reasonable to minimize the amount of the loss and that, having so minimized the loss, the insured is entitled to the amount expended by it for the benefit of the insurer.

The CDI is not mandating policy terms. The relevant policy terms already exist. When insureds purchase automobile coverage they have a reasonable expectation that certain minimum expenses will be covered in the event of a loss, such as towing and storage charges. The proposed amendment to 2695.8(m) sets forth the minimum claims standard in paying the

reasonable towing and storage charges incurred in performing the duty to protect the vehicle, as supported by case law. CIC Section 790.03(h)(1) prohibits an insurer from misrepresenting insurance policy provisions relating to coverage. By denying or reducing claims for towing and storage (in the presence of the duty-to-protect clause) the insurer is misrepresenting its policy provisions.

Also, under an auto liability policy, the insurer is required to pay what the insured is legally liable for. California Civil Code Section 3333 states:

> 3333. For the breach of an obligation not arising from contract, the measure of damages, except where otherwise expressly provided by this Code, is the amount which will compensate for all the detriment proximately caused thereby, whether it could have been anticipated or not.

In third party automobile liability cases, this civil code section has been applied to require payment of reasonable towing and storage charges proximately caused by the negligent party.

In order to clarify the intent of this regulation, the Department proposes an edit to this section as follows:

(m) ~~(l) Every~~ **The** insurer shall **pay reasonable towing and storage charges incurred by the ~~claimant~~ insured and** provide reasonable notice to ~~a claimant~~ **the insured** before terminating payment for storage charges~~,~~ so that the ~~claimant~~ **insured** has time to remove the vehicle from storage. **Once liability has been determined, an insurer shall pay all reasonable towing and storage charges incurred by a third party claimant and provide reasonable notice to the claimant before terminating payment for storage charges so that the claimant has time to remove the vehicle from storage. The payment to a third party claimant may be prorated based upon the comparative fault of the parties involved.**

Comment No.: **35**
Section: **2695.8(m)**
Commentator: Barger & Wolen LLP for 21st Century Insurance Company
Date of Comment: May 7, 2002
Type of Comment: Written Document

Summary of Comment: The Act does not authorize the Department to mandate that insurers cover towing and storage costs, and there is no public policy reasons to require insurers to pay these costs. The amendment is also unclear in that it may require insurers to pay towing and storage for mechanical breakdown.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it in part and accepts it in part. While broadly written, the intent of the proposed language is supported by statutory authority and case law. The proposed language does not require payment of towing and storage charges for mechanical breakdown. All automobile insurance policies contain a clause that places an affirmative duty on the insured to protect the vehicle from further loss. As an example, a certain major insurer places a duty upon the insured to ***"protect the damaged vehicle. We will pay any reasonable expense incurred to do it."*** Other insurers have a similar provision. Courts have consistently held that in the presence of such a clause, the

insured may recover expenses including storage and towing costs incurred to protect the vehicle from further loss. (See Couch on Insurance, § 54:174; Appleman's §3885; and 7A Am Jur 2d § 424). It is currently industry practice to pay reasonable towing and storage charges as part of the standard automobile physical damage insurance coverage offered to insureds. However, some insurers will ignore this portion of the policy and deny or reduce claims for towing and storage expenses.

Further, as stated in 7A Am Jur 2d § 424, even in the absence of a "protection of property" clause, it has been held that an insured is entitled to reimbursement from the insurer for costs incurred in protecting against further loss after the insured vehicle has been in an accident. In this regard it has been said that, an insured must do everything reasonable to minimize the amount of the loss and that, having so minimized the loss, the insured is entitled to the amount expended by it for the benefit of the insurer.

The CDI is not mandating policy terms. The relevant policy terms already exist. When insureds purchase automobile coverage they have a reasonable expectation that certain minimum expenses will be covered in the event of a loss, such as towing and storage charges. The proposed amendment to 2695.8(m) sets forth the minimum claims standard in paying the reasonable towing and storage charges incurred in performing the duty to protect the vehicle, as supported by case law. CIC Section 790.03(h)(1) prohibits an insurer from misrepresenting insurance policy provisions relating to coverage. By denying or reducing claims for towing and storage (in the presence of the duty-to-protect clause) the insurer is misrepresenting its policy provisions.

Also, under an auto liability policy, the insurer is required to pay what the insured is legally liable for. California Civil Code Section 3333 states:

> 3333. For the breach of an obligation not arising from contract, the measure of damages, except where otherwise expressly provided by this Code, is the amount which will compensate for all the detriment proximately caused thereby, whether it could have been anticipated or not.

In third party automobile liability cases, this civil code section has been applied to require payment of reasonable towing and storage charges proximately caused by the negligent party.

In order to clarify the intent of this regulation, the Department proposes an edit to this section as follows:

(m) ~~(l) Every~~ **The** insurer shall **pay reasonable towing and storage charges incurred by the ~~claimant~~ insured and** provide reasonable notice to ~~a claimant~~ **the insured** before terminating payment for storage charges~~,~~ so that the ~~claimant~~ **insured** has time to remove the vehicle from storage. **Once liability has been determined, an insurer shall pay all reasonable towing and storage charges incurred by a third party claimant and provide reasonable notice to the claimant before terminating payment for storage charges so that the claimant has time to remove the vehicle from storage. The payment to a third party claimant may be prorated based upon the comparative fault of the parties involved.**

Subsection 2695.85(a)

Comment No.: **29**
Section: **2695.85(a)**
Commentator: Steve McManus, State Farm Insurance Companies
Date of Comment: May 9, 2002
Type of Comment: Written Document

Summary of Comment: This subsection would require an insurer to provide a copy of the auto body repair consumer bill of rights to the particular insured filing the insurance claim or to all named insureds at renewal. These standards are not required by statute and are burdensome.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it. The requirement of providing the bill of rights to all named insureds upon renewal of the policy is necessary to carry out the intent of the statute, California Insurance Code Section 1874.87. Otherwise, only new insureds, which are a very small percentage of the population, would receive the benefit of this disclosure. In reference to providing the particular insured filing the claim with the bill of rights, this provision is necessary since some policies have several insureds. If the particular insured that files the claim is not provided with the bill of rights, he or she would not have the benefit of having the protections disclosed at the critical time of a claim when these protections are triggered.

Comment No.: **4**
Section: **2695.85(a)**
Commentator: John Metz
Date of Comment: April 24, 2002
Type of Comment: Written Document

Summary of Comments: The Commentator suggests amendments to subsection 2695.85(a) that would require the Auto Body Repair Consumer Bill of Rights be provide at the time of application for an automobile insurance policy, at the time a policy is issued, "**and"** following an accident or loss that is reported to the insurer. The current language is **"or"** and permits the insurer to provide this notice at any of the three times.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it. The options of when the Auto Body Repair Consumer Bill of Rights must be provided are enumerated in the authorizing statute, CIC Section 1874.87(a). Therefore, this requirement can only be changed by legislation.

Subsection 2695.85(c)

Comment No.: **13**
Section: **2695.85(c)**
Commentator: G. Diane Colborn, Personal Insurance Federation of California (PIFC)
Date of Comment: May 7, 2002
Type of Comment: Written Document Accompanying Oral Testimony

Summary of Comment: This section modifies the Auto Body Consumer Bill of Rights form that insurers are required to provide to claimants. Section 3 of the form is modified to provide that every insurer shall pay reasonable towing and storage charges. This provision, like subsection 2695.8(m) is without statutory authority and is inconsistent with Insurance Code Section 1874.87. That section provides that the bill of rights shall include information about the consumer's right to be informed about coverage for towing services, but does not require that insurers provide towing services as a mandated coverage.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it in part and accepts it in part. First, as noted above, the commentator appears to be confusing towing services provided after a mechanical breakdown and towing charges incurred after an accident. The intent of this section is to apply only to towing charges incurred after an accident or other covered loss.

Second, the Department is not mandating coverage. As noted above, the relevant policy terms already exist. The proposed amendment to 2695.85(c) mirrors the standard set forth in Section 2695.8(m) and provides notice to the insured as to what expenses are covered.

In order to mirror the proposed changes to 2695.8(m), as noted above, we propose an edit to the bill of rights section as follows:

> Section 2695.85(c), item #3, to be amended as follows:
>
> 3. BE INFORMED ABOUT COVERAGE FOR TOWING AND STORAGE SERVICES. **THE** ~~EVERY~~ INSURER SHALL PAY REASONABLE TOWING AND STORAGE CHARGES INCURRED BY THE INSURED **TO PROTECT THE VEHICLE** AND PROVIDE REASONABLE NOTICE TO AN INSURED BEFORE TERMINATING PAYMENT FOR STORAGE CHARGES SO THAT THE INSURED HAS TIME TO REMOVE THE VEHICLE FROM STORAGE.

Comment No.: **29**
Section: **2695.85(c)**
Commentator: Steve McManus, State Farm Insurance Companies
Date of Comment: May 9, 2002
Type of Comment: Written Document

Summary of Comment: Paragraph 3 in the Consumer Bill of Rights has the same infirmities detailed in the comments on 2695.8(m), above. This provision lacks clarity and statutory authorization. It should be removed.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it in part and accepts it in part. The Department has the authority for this proposed language. The proposed amendment to 2695.85(c) mirrors the standard set forth in Section 2695.8(m) and provides notice to the insured as to what expenses are covered.

In order to mirror the proposed changes to 2695.8(m), as noted above, we propose an edit to the bill of rights section as follows:

Section 2695.85(c), item #3, to be amended as follows:

3. BE INFORMED ABOUT COVERAGE FOR TOWING AND STORAGE SERVICES. **THE** ~~EVERY~~ INSURER SHALL PAY REASONABLE TOWING AND STORAGE CHARGES INCURRED BY THE INSURED **TO PROTECT THE VEHICLE** AND PROVIDE REASONABLE NOTICE TO AN INSURED BEFORE TERMINATING PAYMENT FOR STORAGE CHARGES SO THAT THE INSURED HAS TIME TO REMOVE THE VEHICLE FROM STORAGE.

Comment No.: **18**
Section: **2695.85(c)**
Commentator: Samuel Sorich, National Association of Independent Insurers
Date of Comment: May 8, 2002
Type of Comment: Written Document

Summary of Comment: The language in the regulation is inconsistent with the statute that created the Bill of Rights. The regulation seeks to impose requirements which are not authorized by statute.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it in part and accepts it in part. The Department has the authority to for this proposed language. The proposed amendment to 2695.85(c) mirrors the standard set forth in Section 2695.8(m) and provides notice to the insured as to what expenses are covered.

In order to mirror the proposed changes to 2695.8(m), as noted above, we propose an edit to the bill of rights section as follows:

Section 2695.85(c), item #3, to be amended as follows:

3. BE INFORMED ABOUT COVERAGE FOR TOWING AND STORAGE SERVICES. **THE** ~~EVERY~~ INSURER SHALL PAY REASONABLE TOWING AND STORAGE CHARGES INCURRED BY THE INSURED **TO PROTECT THE VEHICLE** AND PROVIDE REASONABLE NOTICE TO AN INSURED BEFORE TERMINATING PAYMENT FOR STORAGE CHARGES SO THAT THE INSURED HAS TIME TO REMOVE THE VEHICLE FROM STORAGE.

Comment No.: **35**
Section: **2695.85(c)**
Commentator: Barger & Wolen LLP for 21st Century Insurance Company
Date of Comment: May 7, 2002
Type of Comment: Written Document

Summary of Comment: The amendment is inconsistent with law in that it requires insurers to cover towing and storage costs.

Response to Comment: The Commissioner has considered the commentator's suggestion and rejects it in part and accepts it in part. The Department has the authority to for this proposed language. The proposed amendment to 2695.85(c) mirrors the standard set forth in Section 2695.8(m) and provides notice to the insured as to what expenses are covered.

In order to mirror the proposed changes to 2695.8(m), as noted above, we propose an edit to the bill of rights section as follows:

Section 2695.85(c), item #3, to be amended as follows:

3. BE INFORMED ABOUT COVERAGE FOR TOWING AND STORAGE SERVICES. **THE** ~~EVERY~~ INSURER SHALL PAY REASONABLE TOWING AND STORAGE CHARGES INCURRED BY THE INSURED **TO PROTECT THE VEHICLE** AND PROVIDE REASONABLE NOTICE TO AN INSURED BEFORE TERMINATING PAYMENT FOR STORAGE CHARGES SO THAT THE INSURED HAS TIME TO REMOVE THE VEHICLE FROM STORAGE.

Comments RE: Section 2695.9

Section 2695.9(a)

Comment No. 4
Commentator: John Metz
Date: April 30, 2002
Type of Comment: Written
Reiterated: May 8, 2002, orally

Summary of Comment: The following changes should be made to this subsection:

(a) Under a replacement cost policy, an insurer shall not withhold payment for a general contractor's overhead and profit or any other cost the insured is reasonably likely to incur in repairing or replacing the covered loss from the actual cash value payment of benefits when those expenses would reasonably ~~reasonably are expected to~~ be incurred in the process of repairing the property to the condition it was in prior to the loss occurring.

These changes are necessary to prevent the claimant from being deprived of benefits to which the claimant is entitled (e.g., investigation, testing and/or construction insurance costs that are likely to be incurred, but that may not be part of a general contractor's overhead and profit or other contract costs.)

Response to Comment: The commissioner has considered the comment and rejects it. There is legal authority for prohibiting withholding payment of overhead and profit. The commentator has provided no authority for his proposed addition to the subsection as to "any other cost."

Comment No. 5
Commentator: Michael Palache, S.P.P.A., Rubin, Palache & Associates, LLC
Date: May 2, 2002
Type of Comment: Written

Summary of Comment: The commentator approves of the prohibition of an insurer's withholding of a general contractor's overhead and profit if those costs are likely to be incurred, for the following reasons:

- Claim settlements are based upon damage caused by an insured peril, the costs of repair of which are based on an estimate prepared by a licensed general contractor who is able and willing to carry out the work.
- The contractor's estimate is the "marketplace" cost.
- The California FAIR Plan method of payment includes overhead and profit.
- This is analogous to Section 2695.8 of the regulations, wherein sales tax must be paid in a total automobile loss whether or not the vehicle is being replaced.

Response to Comment: The commissioner has considered the comment and accepts it.

Comment No. 11, 38, 26
Commentator: Jeffrey J. Fuller, Association of California Insurance Companies (ACIC)
Date: May 7, 2002
Type of Comment: Written
Also commented by: Bill Gausewitz, American Insurance Association
Date: May 9, 2002
Type of Comment: Written
Also commented by: Ruben Cruz, Safeco Insurance Company
Date: May 9, 2002
Type of Comment: Written
Also commented by: Michael Burton, Safeco Insurance Company
Date: May 9, 2002
Type of Comment: Oral

Summary of Comment: Payments should not be required to be made for expenses not actually incurred. Such a requirement would necessitate subsequent validation that work has been performed, thus rendering it virtually impossible for insurers to close claim files. Insurance is designed to indemnify for losses, not anticipated contractor overhead and profit.

Response to Comment: The commissioner has considered the comment and rejects it. The insurer's ability to close a claim file is second to the requirements of good faith. Where a contractor's overhead and profit would reasonably be incurred in the repair or replacement of damaged property covered by a policy, it should in all fairness be paid. If not actually incurred, either the insured has acted as his or her own contractor, thus is entitled to be indemnified for his or her time and effort, or the amount can be deducted from other benefits still due and payable under the policy.

Comment No. 18, 26
Commentator: Samuel Sorich, National Association of Independent Insurers
Date: May 8, 2002
Type of Comment: Written
Also commented by: Ruben Cruz, Safeco Insurance Company
Date: May 9, 2002
Type of Comment: Written

Summary of Comment: The requirement that contractor's overhead and profit be paid even when those expenses are not incurred conflicts with the basic principle that a property insurance policy is intended to indemnify the insured, not enrich the insured.

Response to Comment: The commissioner has considered the comment and rejects it. The subsection is not intended to, nor would it in the vast majority of claims, enrich the insured, where those costs are likely to be incurred.

Summary of Comment: Insurance Code section 10102 contains a description of replacement cost coverage that indicates a legislative determination that an insurer may condition the payment of replacement costs on the actual, incurred expense of repairing the damaged dwelling, as follows:

> Your policy will specify whether you must actually repair or replace the damaged or destroyed dwelling in order to recover replacement costs.

The subsection's requirement to pay overhead and profit whether incurred or not conflicts with Section 10102.

Response to Comment: The commissioner has considered the comment and rejects it. The legislative history of Insurance Code, section 10102, shows that the statute was intended to reflect policy language existing at the time the bill was enacted, and that the statute was to be amended by the Commissioner on an ongoing basis to accommodate changes in policies and the law. That section does not mandate that certain language be included in policies.

Summary of Comment: The Initial Statement of Reasons states that the subsection reflects current case law; however, the authority Note to Section 2695.9 cites no cases. The statutes cited in the Note make no mention of the payment of overhead and profit expenses when they are expected to be incurred.

Response to Comment: The commissioner has considered the comment and accepts it. The following case citations will be added to the Note, under "Reference": *Gilderman v. State Farm Ins. Co.* (1994) 437 Pa.Super. 217 [649 A.2d 241]; *Salesin v. State Farm Fire & Casualty Ins. Co.* (1998) 229 Mich.App. 346 [581 N.W.2d 781.

Comment No. 38
Commentator: Bill Gausewitz, American Insurance Association
Date: May 9, 2002
Type of Comment: Written

Summary of Comment: To the extent that this proposal purports to dictate the terms of an insurance contract, it is not authorized.

Response to Comment: The commissioner has considered the comment and rejects it. No new insurance policy terms are required to effectuate this subsection, any more than does the longstanding tenet, "An insurer must consider the interests of its insureds as much as or more than its own."

Summary of Comment: This proposal would facilitate insurance fraud. Having the carrier withhold contractor's overhead and profit protects against fraud (1) by helping avoid the situation in which an insured receives payments but then does not actually have the work done, and (2) by helping ensure that work that is done is done to the satisfaction of the policyholder

since a contractor is far less likely to walk away from a poorly performed project if the overhead and profit has yet to be paid.

Response to Comment: The commissioner has considered the comment and rejects it. This proposal will facilitate the insured having sufficient funds with which to pay a contractor and have the necessary covered work performed.

Comment No. 26
Commentator: Ruben Cruz, Safeco Insurance Company
Date: May 9, 2002
Type of Comment: Written

Summary of Comment: Implementation of this subsection would increase insurers costs, since insurers would be responsible for paying for overhead and profit that may never be incurred.

Response to Comment: The commissioner has considered the comment and rejects it. Costs will not increase for those insurers that already include contractor's overhead and profit in their actual cash value payments. Costs also will not increase, at all or appreciably, for those insurers paying actual cash value where contractor's overhead and profit likely will be incurred.

Section 2695.9(b)(2)

Comment No. 4
Commentator: John Metz
Date: April 30, 2002
Type of Comment: Written

Summary of Comment: The following additions should be made to this subsection:

> (2) When a loss requires replacement of items and the replaced items do not match in **kind,** quality, **fit,** color or size, the insurer shall replace all items in the damaged area so as to conform to a reasonably uniform appearance appearance **at least equal to its condition prior to the loss**.

The changes in this paragraph are necessary to clarify the required standard of repair. Appearance is an essential element of restoration of damaged property to its condition prior to the loss. If the repair met all the other criteria and the appearance was not at least equal, the damaged property would not be restored to its condition prior to the loss.

Response to Comment: The commissioner has considered the comment and rejects it, as it is outside the scope of the rulemaking. There has been no change to this subsection.

Section 2695.9(c)

Comment No. 11
Commentator: Jeffrey J. Fuller, Association of California Insurance Companies (ACIC)
Date: May 7, 2002
Type of Comment: Written

Summary of Comment: The commissioner should consider adding a provision to deal with emergency situations in which an insured may be willing to utilize a designated contractor.

Response to Comment: The commissioner has considered the comment, rejects it in part and accepts it in part. Among the insured's duties under the policy is the duty to mitigate damage. When the insured fails to fulfill his/her duties under the policy, the insurer has adequate recourse.

However, the subsection will be changed to read as follows:

> **(c) No insurer shall require that the insured have the property ~~be~~ repaired by a specific individual or entity.**

This change is consistent with Insurance Code section 2071's "Company's options" clause, which provides the insurer the option (among others) to repair the property itself.

Comment No. 29
Commentator: Steve McManus, State Farm Insurance Companies
Date: May 9, 2002
Type of Comment: Written

Summary of Comment: This provision is not statutorily authorized and, in addition, is in direct conflict with prescribed language in Insurance Code section 2071, which states, under "Company's options":

> It shall be optional with this company to take all, or any part, of the property at the agreed or appraised value, and also to repair, rebuild or replace the property destroyed or damaged with other of like kind and quality within a reasonable time, on giving notice of its intention so to do within 30 days after the receipt of the proof of loss herein required.

Response to Comment: The commissioner has considered the comment and accepts it. The language will be changed as follows:

> **(c) No insurer shall require that the insured have the property ~~be~~ repaired by a specific individual or entity.**

This change is consistent with Insurance Code section 2071's "Company's options" clause, which provides the insurer the option (among others) to repair the property itself.

Section 2695.9(d)(2)

Comment No. 29
Commentator: Steve McManus, State Farm Insurance Companies
Date: May 9, 2002
Type of Comment: Written

Summary of Comment: The phrase "the insurer shall cause the damaged property to be restored" implies that insurers, not insureds, direct the property repairs. The insured, in most cases, selects the repair contractor. The insurer's traditional role in the repair process is evaluating the loss and paying or denying the claim. Changing these roles is not authorized by statute.

Response to Comment: The commissioner has considered the comment and rejects it. The proposed language appropriately places the responsibility for the quality of repairs where it belongs, with the insurer, when the insurer has suggested or recommended a specific individual or entity to make the repairs.

Summary of Comment: The phrase "restored to no less than its condition prior to the loss and repaired in a manner which meets accepted trade standards for good and workmanlike construction" is unclear. Most property policies provide for repairs and restoration to be performed to a standard of similar or common construction, recognizing advancements made in building technology. If that is what is intended in the phrase "accepted trade standards" it is unclear.

Also, some insurers may offer coverage options for "same or similar" repair of certain property features, like plaster walls. The proposed subsection does not appear to recognize the commercial availability of such coverage options.

Response to Comment: The commissioner has considered the comment and rejects it. The term, "accepted trade standards," is taken from Contractors' State License Law, California Business and Professions Code, section 7109:

> (a) A willful departure in any material respect from accepted trade standards for good and workmanlike construction constitutes a cause for disciplinary action . . .

Section 2695.9(e)

Comment No. 4
Commentator: John Metz
Date: April 30, 2002
Type of Comment: Written

Summary of Comment: The following addition should be made to this subsection:

> **. . . The insurer shall take reasonable steps to verify that the repair or rebuilding costs utilized by the insurer or its claims agents are accurate and representative of the then current costs in the local market area . . . .**

This change is necessary to clarify that the value of loss or damage is determined by the actual market costs at the time of the loss or damage. The actual market costs can and do change significantly based on many factors independent of an individual claim, e.g. the supply of and demand for specific materials and skilled craftsmen. The prices can shift dramatically within a very short time, as exemplified by the catastrophic shift in actual market costs that occurred after the Loma Prieta and Southern California earthquakes and Oakland Hills Firestorm. This will

protect both insurer and claimant from paying or receiving more or less than is required under the policy. It is only the real market value, at the time the settlement is concluded and the claimant has money-in-hand to act, that truly reflects the amount of the benefit owed by the insurer and that to which the claimant is entitled. Any deviation results in either over- or under-payment and unfair competition.

Response to Comment: The commissioner has considered the comment and rejects it. The language is unnecessary and awkward.

Section 2695.9(e)(2)

Comment No. 28
Commentator: Douglas A. Lutgen, California State Automobile Association Inter-Insurance Bureau
Date: May 9, 2002
Type of Comment: Written

Summary of Comment: This subsection would prevent insurers from voluntarily offering the claimant the identity of a repair entity or individual who can make property repairs for the amount of the insurer's written estimate. This is anti-competitive, restricts the free speech rights of insurers and appears to have no statutory authority. It would limit the dissemination of accurate, even helpful information and can deprive a claimant of useful knowledge. The second sentence of the subpart provides ample consumer protection in case, for whatever reason, repairs performed by the suggested shop initially prove inadequate. The phrase "if requested by the claimant" should be deleted.

Response to Comment: The Commissioner has considered the comment and rejects it. This section is analogoug to Section 2695.8(i)(2). As proposed and as currently written, Section 2695.8(i)(2) contains the "if requested by the claimant" language. An insurer under the current regulation is precluded from voluntarily providing a claimant with the identity of a repair shop that will perform repairs for the amount of the insurer's estimate in an effort to reduce the payment to the insured. No substantive change has been made on this issue. Therefore, this comment is outside the scope of this process. However, it should be noted that this subsection does not preclude an insurer from recommending a repair shop to its insured as long as it is done in compliance with subsection 2695.8(f). Subsection 2695.8(i)(2) only applies when the insured and insurer do not agree as to the cost of making the necessary repairs and the insurer attempts to reduce the insured's estimate.

Comment No. 29
Commentator: Steve McManus, State Farm Insurance Companies
Date: May 9, 2002
Type of Comment: Written

Summary of Comment: The language "the insurer shall cause the damaged property to be restored" implies that insurers, not insureds, direct the property repairs. The insured, in most cases, selects the repair contractor. The insurer's traditional role in the repair process is

evaluating the loss and paying or denying the claim. Changing these roles is not authorized by statute.

Response to Comment: The Commissioner has considered the comment and rejects it. This section is analogous to provisions of these regulations contained in Section 2695.8, as respects automobile insurance claims. The Commissioner believes similar safeguards and options should be provided for first party residential and commercial property insurance claimants.

Section 2695.9(e)(3)

Comment No. 4
Commentator: John Metz
Date: April 30, 2002
Type of Comment: Written
Reiterated: May 8, 2002, orally

Summary of Comment: In the matter of vehicle repair, Section 2695.8(i)(2) sets forth the proper standard as it exists and with the proposed changes, where the insurer provides the claimant with the name of a repairer that will make the repairs for the amount of the written estimate:

> **The insurer** shall ~~assure~~ **cause the damaged vehicle to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy or as otherwise allowed by these regulations** ~~that the repairs are performed in a workmanlike manner.~~

In the case of residential and commercial property, a similar standard should be imposed where the insurer is not paying the difference between its written estimate and a higher estimate obtained by the claimant (proposed Section (e)(1)) or providing the claimant with the name of at least one repair individual or entity that will make the repairs for the amount of the written estimate (proposed Section (e)(2). Therefore, Section (e)(3) should read:

> **(e) . . . If the claimant subsequently contends, based upon a written estimate which he or she obtains, that necessary repairs will exceed the written estimate prepared by or for the insurer, the insurer shall:**
>
> **(3) reasonably adjust any written estimates prepared by the repair individual or entity of the insured's choice and provide a copy of the adjusted estimate to the claimant and guarantee that the individual or entity of the insured's choice will make the repairs in a workmanlike manner and which restores the property to its condition prior to the loss at no additional cost to the insured other than as stated in the policy or as otherwise allowed by these regulations.**

Response to Comment: The commissioner has considered the comment, accepts it in part and rejects it in part. The commissioner agrees that similar safeguards and options should be provided for first party residential and commercial property insurance claimants. The effort to

provide similar standards, however, has resulted in language different from the commentator's suggested language, both in Section 2695.8 and in Section 2695.9.

Section 2695.9(f)

Comment No. 18
Commentator: Samuel Sorich, National Association of Independent Insurers
Date: May 8, 2002
Type of Comment: Written

Summary of Comment: This subsection would bar any legal proceeding not specified in Insurance Code section 2071 once the appraisal process is started. This is an unauthorized restriction on the right to pursue legal actions. Some lawsuits may be necessary to pursue during the appraisal process, although they are not specifically referenced in Section 2071, e.g., a declaratory relief action regarding the insurance coverage for a loss. The subsection should be deleted.

Response to Comment: The Commissioner has considered the comment and rejects it. The appraisal process is intended to be less time consuming and more cost efficient than civil litigation. When the insurer interrupts the appraisal process with legal proceedings designed to draw out that process and increase its costs, thus delaying further a conclusion to the claim, the insured is penalized for having invoked appraisal in good faith. The subsection is intended to obviate such delays and expenses.

Comments RE: Section 2695.10

Comment No.: **38**
Section: **2695.10**
Commentator: **American Insurance Association, Bill Gausewitz**
Date of comment: **5/9/02**
Type of comment: **Written**

Summary of comment: The proposal largely repeals current language. The rationale for these changes is that the subject is addressed through the requirements of 2695.7. That section is general and does not recognize the unique nature of surety bonds. The repeal of most of 2695.10 is unnecessary and its impact is unclear. The current regulations have operated well for several years. This subsection should be retained.

Response to comment: The Commissioner has considered this comment and rejects it. Although the tripartite relationship that exists in connection with a surety bond is unique, statutory and case law does not preclude the application of these regulations to surety claims. The proposed amendment is necessary because the minimum standards for settling claims are as applicable to surety as to other types of claims. These minimum standards work to protect the claimant regardless of the complexity of the claim.

Comments RE: Section 2695.10(a)

Comment No.: **32**
Section: **2695.10(a)**
Commentator: **Surety Company of the Pacific, Geissler & Nimoy**
Date of comment: **5/9/02**
Type of comment: **Written**

1. Summary of comment: Surety insurance claims involve a tri-partite dynamic which includes the surety, the bond principal and the claimant. It is not unusual for a surety claim to turn on a factual dispute between a principal and claimant (obligee). The proposed section would force a surety company to always accept the word of the claimant against the word of the principal in a factual dispute. The result would be inconsistent with existing law, specifically *Cates Construction, Inv. v Talbot Partners*. The California Supreme Court has ruled that a surety has a duty of good faith and fair dealing to the bond principal even in contract disputes involving situations in which it is difficult for the surety to determine which party is in the right. The surety's obligation to the principal is important since the principal must reimburse the surety for a payment from a bond.

Response to comment: The commissioner considered the comment and rejects it. Nothing in the proposed language requires a surety to accept the word of the claimant over the word of the principal. The language merely prohibits a surety from denying a claim based "solely" on the principal's denial of liability. The surety is required to investigate the claim and weigh the evidence and then make a decision. The surety may deny the claim if the evidence supports the principal's denial of liability. This is in keeping with, and complements, the surety's duty to perform a diligent investigation as required by 2695.7(d).

2. Summary of comment: The record of the rule making proceeding does not include "substantial evidence" that the proposed regulation meets the "necessity" standard. (Emphasis in Original) There is no evidence that bond principals, as a class, are less reliable or trustworthy than claimants (obligees) as a class.

Response to comment: The commissioner considered the comment and rejects it. The proposed language does not require a surety to consider claimants as more trustworthy than the principal. Again, the language simply prohibits a surety from denying a claim solely based on the principal's denial of liability.

3. Summary of comment: The regulation is not readily understandable and is subject to more than one meaning.

Response to comment: The commissioner considered the comment and rejects it. The proposed language is clear, a surety may not deny a claim based solely upon a principal's denial of liability.

Comment No.: **4**
Section: **2695.10(a)**
Commentator: **John Metz**
Date of comment: **4/24/02**
Type of comment: **Written**

Summary of comment: An improper delay produces harm, as does improper denial. For this reason the following language is proposed:

"(a) No insurer may **delay payment of or** deny a claim…"

Response to comment: The commissioner considered the comment and rejects it. The commentator's concerns are addressed in 2695.7(b) & (d).

Comments RE: Section 2695.10(b)

Comment No.: **15**
Section: **2695.10(b)**
Commentator: **Surety Association of American**
Sedgwick, Detert, Moran & Arnold
Marilyn Klinger
Date of comment: **5/8/02**
Type of comment: **Written & Oral**

1. Summary of comment: The proposed language is more burdensome for surety insurers than other insurers and is virtually impossible to comply with in connection with contract surety bonds. Section 2695.7(b) and (c) would require sureties to accept or deny a claim within 40 days of receiving proof of claim (albeit allowing more time if additional information is needed). Where the surety is simply the guarantor of the principal's obligation, the surety has no knowledge with respect to a claim against the principal unless it has an opportunity to discuss the claim with the principal and review any documents relative to the obligation. However, the proposed Section 2695.10(b) provides that " a principal's absence, non-cooperation, or failure to meet the bonded obligation shall not excuse delay by the insurer in determining whether a claim should be accepted or denied." Based on the foregoing, elimination of the bulk of
Section 2695.10 is inappropriate, unnecessary and will create a huge burden upon the surety. If, however, the revisions are to be adopted, at a minimum, Section 2695.10(b) should be revised by using one of the two following alternatives:

" (b) A principal's absence, non-cooperation, or failure to meet the bonded obligation shall not excuse more than a forty (40) day delay by the insurer in determining whether a claim should be accepted or denied.

OR

(b) A principal's absence, non –cooperation, or failure to meet the bonded obligation shall not excuse delay by the insurer in determining whether a claim should be accepted or denied; however, if the reason that more time is required to determine whether a claim should be accepted and/or denied in whole or in part is the principal's absence or non-cooperation, the insurer shall provide the claimant, within the time frame provided in subsection 2695.7(b), with written notice of the need for additional time,…"

If the principal is either absent or uncooperative, admittedly, the sureties do need to respond to the claim, but they will need more time. Our proposed language asks for an additional 40 days on top of the 40 (in 2695.7(b)).

Response to comment: The commissioner considered the comment and rejects it. The proposed language complements 2695.7(b), (c) & (d). If a surety needs more time to investigate a claim, the language in 2695.7(c) provides ample time for further investigation.

Comments RE: Section 2695.10(c)

Comment No.: **15**
Section: **2695.10(c)**
Commentator: **Surety Association of American**
Sedgwick, Detert, Moran & Arnold
Marilyn Klinger
Date of comment: **5/8/02**
Type of comment: **Written & Oral**

Summary of comment: The proposed language is contrary to existing law. Specifically, California Civil Code section 2845 which provides:

" A surety may require the creditor…to proceed against the principal or pursue any other remedy in the creditor's power which the surety can not pursue, and which would lighten the surety's burden: and if the creditor neglects to do so, the surety is exonerated to the extent to which the surety is thereby prejudiced."

Requiring that the surety not refer a claimant to the principal for performance under the bond, without first establishing that the principal would meet the bonded obligation, is totally inconsistent with the surety's unconditional statutory right to require the claimant to proceed against the principal.

Surety bond claims presented under bonds that relate to transactions between businesses, particularly on large commercial construction projects, are truly different than claims under insurance policies. By the same token, there may be similarities to traditional insurance claims when it comes to contractor's license bonds which are more in the nature of consumer bonds. SAA suggests that the current regulations be preserved for surety bond claims in general, but changes could apply to contractor's license bond claims. Or alternatively, the current regulations could be preserved for surety bond claims handling, but DOI could prepare a separate section for contractor's license bond claims.

Response to comment: The commissioner considered the comment and rejects it. The proposed language simply requires the surety to document facts relied upon to support its conclusion that the principal would meet the obligation. Nothing in the proposed language prevents a surety from referring the claimant to the principal to fulfill the obligation. However, the commentator is reminded that California Civil Code Section 2845 is permissive not obligatory on the part of the surety. The proposed amendment is necessary because the minimum standards for settling claims are as applicable to surety as to other types of claims. These minimum standards work to protect the claimant regardless of the complexity of the claim. Further, the Civil Code does not distinguish between contract license bonds and other types of bonds.

Comment No.: **4**
Section: **2695.10(c)**
Commentator: **John Metz**
Date of comment: **4/24/02**
Type of comment: **Written**

Summary of comment: Recommends the word "verified" be added to the subsection:

"…without first documenting in its claim file the **verified** facts relied upon to support its conclusion…"

Response to comment: The commissioner considered the comment and rejects it. The additional word is not necessary. The commentator's concerns are addressed in 2695.7(d).

Comments RE: Eliminating Current Section 2695.10(g)

Comment No.: **16**
Current Section: **2695.10(g)**
Commentator: **Developers Surety and Indemnity Company**
Robins, Kaplan, Miller, Ciresi LLP, David C. Veis
Date of comment: **5/8/02**
Type of comment: **Written**

Summary of comment: Eliminating this section lacks necessity and is inconsistent with existing law. The factors outlined in the deleted language are consistent with factors which the courts and legislature have deemed important in the evaluating a surety claim. The Initial Statement of Reasons for the Proposed Amendments states "This section is deleted as the language is adequately covered in Subsection 2695.7 which subsection is applicable to surety…" There is absolutely nothing in Section 2695.7 which deals with any of the unique aspects of suretyship recognized in existing 2695.10(g). The deleted language should be restored.

Response to comment: The commissioner considered the comment and rejects it. While the commissioner does, in fact, recognize that surety claims may be complex and that the surety is a member of the tri-partite relationship, the commissioner finds that language in 2695.7(g) and 2695.12 adequately addresses the commentator's concerns.

Comments RE: Section 2695.11

Comment No.: **4**
Section: **2695.11 (Title)**
Commentator: John Metz
Date: April 30, 2002
Type of Comment: Written

Summary of Comment: The title of this section should include the word "health" as follows: "Additional Standards Applicable to Life, Health and Disability Insurance Claims." This addition

is necessary to clarify that these regulations apply to health insurance as well as life and disability.

Response to Comment: The commissioner considered the comment and rejects it. No change is necessary. The term "Disability" as used in the context of insurance, is recognized as including "health" insurance. Insurance Code Section 106 provides:
(b) In statutes that become effective on or after January 1, 2002, the term "health insurance" for purposes of this code shall mean an individual or group disability insurance policy that provides coverage for hospital, medical, or surgical benefits.

Comments RE: Section 2695.11(a)(1)

Section 2695.11(a)(1)
Comment No.: **4**
Commentator: John Metz
Date: April 30, 2002
Type of Comment: Written

Summary of Comment: The word "verified" should be added to subsections (a)(1) and (2) as follows, unless the changes suggested to Section 2695.3(b) by the commentator are adopted:
(a) No insurer shall seek reimbursement of an overpayment or withhold any portion of any benefit payable as a result of a claim on the basis that the sum withheld or reimbursement sought is an adjustment or correction for an overpayment made on a prior claim arising under the same policy unless:
(1) the insurer's files contain clear, verified, documented evidence of an overpayment and written authorization from the insured or assignee, if applicable, permitting such the reimbursement or withholding procedure, or
(2) the insurer's files contain clear, verified, documented evidence pursuant to section 2695.3 of all of the following: . . .
This addition is necessary to assure the truthfulness and accuracy of the information upon which claims processing and determinations are based. It is also consistent with the current duty of claimants. It will reduce the number of disputes and the amount of litigation. It will severely hamper the opportunity for misconduct by unscrupulous insurers. It will protect insureds and claimants, foster competition among honest insurers and limit the Department's regulatory burden by reducing the number of unfair claims acts or practices.

Response to Comment: The commissioner considered the comment and rejects it. Verification, as in certification under oath, is unnecessary in the context of seeking reimbursement of an overpayment where written authorization from the insured or assignee is in the file. To require verification in this context and not in any others would be an anomaly.

Comments RE: Section 2695.11(a)(2)

Section 2695.11(a)(2)
Comment No.: **4**
Commentator: John Metz
Date: April 30, 2002

Type of Comment: Written

1. Summary of Comment: The prefix "mis" should be added to subsection (a)(2)(C) as follows:

> (C) The insurer notifies the insured within six (6) months of the date of the error, except that in instances of error prompted by **mis**representations or nondisclosure of claimants or third parties, the insurer notifies the insured within fifteen (15) calendar days after the date of discovery of such error. . . .

It is the insurer's duty to attend to its business in a competent manner, and to conduct a thorough and prompt investigation of the facts to assure that payment is correct at the time it makes the determination to pay. The current language can only allow an unscrupulous insurer to engage in mischief to the detriment of its own disabled insureds and competitors who pay attention to the material details of their business.

Response to Comment: The commissioner considered the comment and rejects it, as it is outside the scope of the rulemaking. This subsection has not been changed.

2. Summary of Comment: The word "draft" should be deleted and the word "check" inserted as follows: ". . . For the purpose of this subsection, the date of the error shall be the day on which the ~~draft~~ **check** for benefits is issued."

The use of "drafts" should be prohibited. Because of the generally longer time period required before payment on a draft is actually made by the issuing bank (during which time the insurer can earn additional interest on the money) and because the insurer retains the ability to stop payment until the funds actually leave the issuing bank, drafts allow the insurer to receive the benefit of settlement without having actually made payment.

Response to Comment: The commissioner considered the comment and rejects it, as it is outside the scope of the rulemaking. This subsection has not been changed.

3. Summary of Comment: A sentence should be added to subsection (a)(2)(D) as follows, unless the changes suggested to Section 2695.3(b) by the commentator are adopted:

> (D) Such notice states clearly the cause of the error and states the amount of the overpayment. **Each statement is to be made under penalty of perjury.**

This addition is necessary to assure the truthfulness and accuracy of the information upon which claims processing and determinations are based. It is also consistent with the current duty of claimants. It will reduce the number of disputes and the amount of litigation. It will severely hamper the opportunity for misconduct by unscrupulous insurers. It will protect insureds and claimants, foster competition among honest insurers and limit the Department's regulatory burden by reducing the number of unfair claims acts or practices.

Response to Comment: The commissioner considered the comment and rejects it, as it is outside the scope of the rulemaking. This subsection has not been changed.

Comments RE: Section 2695.11(b)

Section 2695.11(b)
Comment No. : 4
Commentator: John Metz
Date: April 30, 2002
Type of Comment: Written

Summary of Comment: The following changes should be made to this subsection:
(b) With each claim payment, the insurer shall provide to the claimant and assignee, if any, an explanation of benefits which shall include the factual and legal bases, and any specific policy provision, condition or exclusion then within the insurer's knowledge, which were relied upon in computing the benefits provided and, if applicable, the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits.
The changes in this paragraph are needed to ensure that the claimant or assignee has the necessary information to verify the correctness of the insurer's determination. The correctness of a claims determination must be supported by these three components. It should present no significant burden to an insurer to maintain this data. In fact, if this information has not been obtained and used in the claims determination, the presumption is that the decision was unsupported - and, therefore, improper. Since these are factors that the insurer already must consider in making its benefit determination, it adds little burden, helps ensure proper payments, and minimizes disputes and litigation.

Response to Comment: The commissioner has considered the comment and rejects it, as it is outside the scope of the rulemaking. There has been no change to this subsection.

Comments RE: Section 2695.11(c)

Section 2695.11(c)
Comment No. : 4
Commentator: John Metz
Date: April 30, 2002
Type of Comment: Written

Summary of Comment: The following addition should be made to the subsection:
(c) An insurer may not impose a penalty upon any insured for noncompliance with insurer requirements for precertification of benefits unless such penalties are specifically and clearly set forth in writing in the policy or certificate of insurance, and which policy or certificate of insurance was delivered to the insured at the time the insurance became effective.

This addition is necessary because it would be patently unfair for an insured to be bound by provisions that the insured never saw, as a result of an insurer's marketing or other decision not to provide the controlling document for the insured's review prior to the insured's decision to buy the insurance.

Where a policy has not yet been issued, all standard exclusions to the insurance coverage, which the insured would not reasonably expect, must be called clearly and plainly to the attention of the

insured if the insurer is to be permitted to rely on these exclusions to avoid payment of benefits under the policy.
Logan v. John Hancock Mutual Life Insurance Company (1974) 41 Cal.App.3d 988, 996. (Also see Russell v. Bankers Life Co. (1975) 46 Cal.App.3d 405, 414.)

Response to Comment: The commissioner has considered the comment and rejects it, as it is outside the scope of the rulemaking. There has been no change to this subsection.

Comments RE: Section 2695.11(d)

Section 2695.11(d)
Comment No.
Commentator: John Metz
Date: April 30, 2002
Type of Comment: Written

1. Summary of Comment: The following additions should be made to the subsection:

> **(d) . . . This notice shall be given within thirty (30) calendar days of the notice (required under Insurance Code Section 10123.13) that the claim is being contested and every thirty (30) calendar days thereafter until a determination is made or legal action is served. In order to rely on this extension, an insurer must have diligently pursued the additional required information.** . . .

This addition is necessary because it is common knowledge that unscrupulous insurers frequently make such demands, often unwarranted, on insureds. Each additional demand placed on a disabled claimant can wreak havoc with their already compromised lives, and lead to an unjust loss of benefits. An insurer, simply by acting in a competent, professional manner and paying attention to its business, would fulfill this condition. Without it, a needless temptation is provided for an insurer to limit or eliminate the payment of benefits simply through its own alleged "carelessness," "lethargy," or understaffed claims departments.

Response to Comment: The commissioner has considered the comment and rejects it. The suggested additional language is unnecessary, as it would be in Section 2695.7(c), as the requirement of diligent investigation is included in new language in Section 2695.7(d).

2. Summary of Comment: The following addition should be made to the subsection:

> **(d) . . . If the determination cannot be made until some future event occurs, the insurer shall comply with this continuing notice requirement by advising the claimant and assignee of the situation, and informing the claimant and assignee of any fact, law or policy provision upon which it is relying in taking this position and providing an estimate as to when the determination can be made.**

This change is necessary to assure that the insurer clearly understands the bases for its decisions and so that the Department, a dissatisfied claimant and/or a reviewing court has a readily

understandable basis for determining the correctness of the decision. It is also necessary because the correctness of a claims determination must be supported by these three components. It should present no significant burden to an insurer to maintain this data. In fact, if this information has not been obtained and used in the claims determination, the presumption is that the decision was unsupported and, therefore, improper.

Response to Comment: The commissioner has considered the comment and rejects it. This subsection mirrors Section 2695.7(c). Additional language is not required as to the continuing notice requirement.

Section 2695.11(d)

Comment No.:	17, 21
Commentator:	Douglas K. deVries, Mart & deVries, Attorneys at Law
Date:	May 8, 2002
Type of Comment:	Written
Also commented by:	Lea-Ann Tratten, Consumer Attorneys of California
Date:	May 8, 2002
Type of Comment:	Written, E-mail

Summary of Comment: The inclusion of the following language in this subsection, together with the amended definition of "proof of claim" in Section 2695.2(s) and language in Section 2695.11(g) (see below), inadvertently may encourage insurers to shift investigative activity to the claimant. It is the insurers' nondelegable duty to reasonably and promptly investigate, evaluate and settle a claim.
(d) . . . This written notice shall specify any additional information the insurer requires in order to make a determination and shall state any continuing reasons for the insurer's inability to make a determination. . . .

Response to Comment: The commissioner has considered the comment and rejects it. Proposed amended Section 2695.7(d) clarifies that it is the insurers' duty to investigate, as follows:
(d) Every insurer shall conduct and diligently pursue a thorough, fair and objective investigation and No insurer shall not persist in seeking information not reasonably required for or material to the resolution of a claim dispute.

Section 2695.11(e)

Comment No. 4
Commentator: John Metz
Date: April 30, 2002
Type of Comment: Written
Reiterated: May 8, 2002, orally

Summary of Comment: The following changes should be made to the subsection:

> **(e) . . . The preauthorization shall be communicated or confirmed in writing to the insured and the medical service provider, and shall explain the scope of the preauthorization and/or denial of authorization, if any, ~~whether the preauthorization is or is not a guarantee of acceptance of the claim~~ and shall**

inform the insured and the medical service provider of any fact, law or policy provision upon which it is relying as the basis for the position it is taking . . . .

This change is necessary to assure that the insurer clearly understands the bases for its decisions and so that the Department, a dissatisfied claimant and/or a reviewing court has a readily understandable basis for determining the correctness of the decision. It is also necessary because the correctness of a claims determination must be supported by these three components. It should present no significant burden to an insurer to maintain this data. In fact, if this information has not been obtained and used in the claims determination, the presumption is that the decision was unsupported and, therefore, improper.

Response to Comment: The commissioner has considered the comment and accepts it. The change will be made, however, in the following form:

(e) When a policy requires preauthorization of non-emergency medical services, the preauthorization must be given immediately but in no event more than five (5) calendar days after the request for preauthorization. The preauthorization shall be communicated or confirmed in writing to the insured and the medical service provider, and shall explain the scope of the preauthorization and whether the preauthorization is or is not a guarantee of acceptance of the claim. In the event the preauthorization is denied, the reason(s) for the denial shall be communicated in writing to the insured and the medical service provider.

Summary of Comment: The following addition should be made to the end of the subsection:

(e) . . . A preauthorization shall be a guarantee of acceptance of the claim.

This change is necessary to avoid the increasingly all-too-familiar situation in which an insurer causes substantial harm to insureds, providers and competitors who do not engage in such devious conduct, by "authorizing" treatment and later refusing to pay for it. Authorization from an insurer is misleading and deceptive if the insurer does not pay. The failure of an insurer to authorize payment is tantamount to a denial. Under the current language, the insurer escapes its duty to plainly say so and support its determination with the facts, legal authorities and policy language of which it is aware at the time it makes that determination. Without such a well-founded basis for its decision, the insurer is violating its duty of good faith and fair dealing to its insured and cold-bloodedly denying benefits without adequate justification.

Response to Comment: The commissioner has considered the comment and rejects it. Because the insurer and the entity it employs in utilization management usually are separate organizations, the suggested language is impracticable.

Section 2695.11(g)

Comment No. 4
Commentator: John Metz
Date: April 30, 2002
Type of Comment: Written

Summary of Comment: The following changes should be made to the subsection:

> **(g) An insurer shall reimburse the insured or medical service provider <u>or other person</u> for <u>any fees and</u> reasonable expenses incurred in copying medical <u>or other</u> records <u>or obtaining any other information from a medical service provider or anyone else, when</u> requested by the insurer.**

These changes are needed to clarify the fact that an insurer has no right to compel an insured, medical service provider or anyone else to expend their time without adequate compensation, or to incur any expense at an insurer's request, unless there is a clear, explicit, unambiguous contractual obligation to do so.

Response to Comment: The commissioner has considered the comment and rejects it. The Department of Insurance has not received consumer complaints that indicate a problem justifying such a broadening of this subsection's language.

<u>Comment No.</u> 17, 21, 4
Commentator: Douglas K. deVries, Mart & deVries, Attorneys at Law
Date: May 8, 2002
Type of Comment: Written
Also commented by: Lea-Ann Tratten, Consumer Attorneys of California
Date: May 8, 2002
Type of Comment: E-mail
Also commented by: Pete Kirkpatrick
Date: May 9, 2002
Type of Comment: Oral

Summary of Comment: The language of this subsection, together with the amended definition of "proof of claim" in Section 2695.2(s) and language in Section 2695.11(d) (see above), inadvertently may encourage insurers to shift investigative activity to the claimant. It is the insurers' nondelegable duty to reasonably and promptly investigate, evaluate and settle a claim. Insurers too often take the position that they are fulfilling their duty to conduct an investigation by overburdening the claimant with repetitive requests for the insured to gather and provide information at the insured's expense.

Because it was the California Medical Association that requested inclusion of this language to assure that health care providers be reimbursed for their cost of copying, the following deletion should be made:

> **(g) An insurer shall reimburse the ~~insured or~~ medical service provider for reasonable expenses incurred in copying medical records requested by the insurer.**

Response to Comment: The commissioner has considered the comment and rejects it. It is not the intention of the commissioner to encourage insurers to burden an insured as suggested above. However, when an insured does incur such costs, he or she should be reimbursed by the insurer.

Comments RE: Section 2695.12, generally

Comment No.: **13**
Section: **2695.12, generally**
Commentator: G. Diane Colborn, Personal Insurance Federation of California
Date of Comment: May 7 and 8, 2002
Type of Comment: Written and Oral

Summary of Comment: The amendments substantially broaden the definition of "knowing" violations such that any violation is now a "knowing" violation under subsection 2695.2(l). Existing provisions that more specifically defined what constitutes an act of noncompliance have been stricken. For example, existing Section 2695.12 (c), which provides that the commissioner shall not consider reasonable mistakes or opinions as to valuation of property, losses or damages when determining a licensee's noncompliance or penalties to be assessed, is stricken. Holding companies strictly liable for reasonable mistakes is unduly harsh and unreasonable.

Response to Comment: The Commissioner has considered the comment, accepts it in part and rejects it in part. The amendments do not broaden the definition of "knowing." Whether an act was the result of a reasonable mistake or opinion is a separate issue from that of whether the act was "knowing."

If an act that is knowingly committed on a single occasion or performed as a business practice is not in compliance with the regulations, it is necessarily in violation of the regulations. If the insurer has actual, implied or constructive knowledge that it is committing an act, even if it does not know that it is committing a violation of the Insurance Code, it is still a violation.

The issue then becomes whether the knowingly committed act or business practice was willful or nonwillful, i.e., whether the insurer knew when the act was committed that it was a violation of the code. The willfulness or nonwillfulness would affect the amount of penalty to be assessed pursuant to Insurance Code Section 790.035.

As to reasonable mistakes or opinions, these should be taken into consideration only in determining whether or how much of a penalty should be assessed. As discussed below in connection with Section 2695.12(c), for clarification purposes, proposed Section 2695.12 is further amended as follows: **(14) the licensee's reasonable mistakes or opinions as to valuation of property, losses or damages.**

Comment No.: **35**
Section: **2695.12, generally**
Commentator: Kent Keller, Barger and Wolen, on behalf of 21st Century Insurance Company
Date of Comment: May 7 and 8, 2002
Type of Comment: Written and Oral

1. Summary of Comment: Under the proposed language, acts in contravention of the regulations are "violations" instead of "noncompliance." This suggests that single acts could be violations of the Code as opposed to merely acts in noncompliance with the regulations. These "violations" would now automatically be subject to penalty, the Department having eliminated

the words "if any" so as to permit the Commissioner to conclude that an act of noncompliance has occurred but that no penalty was appropriate.

Response to Comments: As the original language to the Preamble makes clear, it is an unfair claims practice for an insurer to commit knowingly on a single occasion any of the sixteen claims settlement practices set forth in Insurance Code Section 790.03(h). If an act that is knowingly committed on a single occasion or performed as a business practice is not in compliance with the regulations, it is necessarily in violation of the regulations. Under the proposed amendments, the Commissioner has the discretion to assess no penalty for a violation, depending upon the evidence submitted under proposed subsection 2695.12(a)

2. Summary of Comment: An insurer's reasonable mistakes should be considered in determining both noncompliance with the regulations and penalties to be assessed.

Response to Comment: The Commissioner has considered this comment, rejects it in part and accepts it in part. If an act is not in compliance with the regulations, it is necessarily in violation of the regulations. A reasonable mistake would not be a willful violation but it is still a violation.

However, an insurer's reasonable mistakes or opinions should be taken into consideration in determining whether or how much of a penalty should be assessed. In order to make that concept clear, proposed Section 2695.12(a) is further amended as follows: **(14) the licensee's reasonable mistakes or opinions as to valuation of property, losses or damages.**

3. Summary of Comment: Under the proposed regulations, in market conduct exams, the procedure seems to be that the Commissioner will detail all "violations" with no expressed procedures for insurers to contest the finding of a "violation." This is inconsistent with Insurance Code Section 790.05

Response to Comment: The Commissioner has considered this comment and rejects it. Nothing in the proposed amendments precludes an insurer from exercising it rights under Insurance Code Section 790.05 to contest at an administrative hearing violations alleged by the Department.

Comment No.: **29**
Section: **2695.12, generally**
Commentator: Steve McManus, State Farm Insurance Companies
Date of Comment: May 9, 2002
Type of Comment: Written

Summary of Comment: The effect of the definitional change of "knowingly committed" to "knowingly" in subsection 2695.2(l) and the changes proposed to this section would make any single violation subject to penalty. This standard ignores the sheer number of claims handled by insurers and requires the Commissioner to levy fines even for isolated, technical, unintended, minor or harmless violations.

Response to Comment: As the original language to the Preamble makes clear, it is an unfair claims practice for an insurer to commit knowingly on a single occasion any of the sixteen claims settlement practices set forth in Insurance Code Section 790.03(h). If an act that is knowingly committed on a single occasion or performed as a business practice is not in compliance with the regulations, it is necessarily in violation of the regulations. However the

Commissioner is not required to levy a fine for every violation. Under the proposed amendments, the Commissioner would have the discretion to assess no penalty for a violation, depending upon the evidence submitted under proposed subsection 2695.12(a).

Comment No.: **Oral - See Transcript in Rulemaking File**
Section: **2695.12, generally**
Commentator: Gary Hernandez, Sonnenschein, Nath & Rosenthal
Date of Comment: May 8, 2002
Type of Comment: **Oral - See Transcript in Rulemaking File**

Summary of Comment: The Department should not remove the requirement that an act be knowingly committed in noncompliance with the regulations, the result being that any error found constitutes a violation.

Response to Comment: The Commissioner has considered this comment and rejects it. As the original language to the Preamble makes clear, it is an unfair claims practice for an insurer to commit knowingly on a single occasion any of the sixteen claims settlement practices set forth in Insurance Code Section 790.03(h). If an act that is knowingly committed on a single occasion or performed as a business practice is not in compliance with the regulations, it is necessarily in violation of the regulations. Under the proposed amendments, the Commissioner has the discretion to assess no penalty for a violation (as in the case of an error.)

Comment No.: **4**
Section: **2695.12, generally**
Commentator: John Metz
Date of Comment: April 24 and May 8, 2002
Type of Comment: Written and Oral

Summary of Comment: The Commentator suggests adding "the promptness and thoroughness of the insurer's investigation" as evidence to be considered by the Commissioner in determining penalties to be assessed.

Response to Comment: The Commissioner has considered this comment and rejects it as redundant. Proposed Section 2695.7(d) already specifies that every insurer shall conduct and diligently pursue a thorough, fair and objective investigation. Under re-lettered Section 2695.12(a)(11), in determining appropriate penalties, the Commissioner is to consider evidence of whether the insurer made a good faith attempt to comply with the regulations, including Section 2695.7(d)'s requirement that the insurer diligently pursue a thorough investigation.

Comment No.: **4**
Section: **2695.12, generally**
Commentator: John Metz
Date of Comment: April 24 and May 8, 2002
Type of Comment: Written and Oral

Summary of Comment: In determining appropriate penalties to be assessed, the Commentator suggests adding evidence of the insurer, under a similar policy, having paid or valued the claim of another insured at a greater amount for substantially the same loss or damage.

Response to Comment: This comment is rejected as it falls outside the scope of the proposed rulemaking.

Comments RE: Section 2695.12(a)(2)

Comment No.: **4**
Section: **2695.12(a)(2)**
Commentator: John Metz
Date of Comment: April 24 and May 8, 2002
Type of Comment: Written and Oral

Summary of Comment: In determining appropriate penalties to be assessed, an insurer's reasonable belief that the claim is fraudulent must be based solely on information that is verified under penalty of perjury and is documented in the file.

Response to Comment: This comment is rejected as it falls outside the scope of the proposed rulemaking. It is unreasonable to require that all information be verified under penalty of perjury. As the current regulations reflect, the insurer is to rely on information that gives it "a good faith and reasonable basis" to believe that the claim is fraudulent

Comments RE: Section 2695.12(a)(7)

Comment No.: **18**
Section: **2695.12(a)(7)**
Commentator: Samuel Sorich, National Association of Independent Insurers
Date of Comment: May 8, 2002
Type of Comment: Oral and Written

Summary of Comment: The proposed change is at odds with Insurance Code Section 790.03(h)'s focus on an insurer's "general business practice" for settling claims. The existing language looks at the number of violations in relation to all claims handled by an insurer and is a valid indication of a general business practice. The proposed changes incorrectly look at the number of violations in relation to the number of claims the Department has chosen to review.

Response to Comment: The Commissioner has considered this comment and rejects it. In order to determine appropriate penalties to be assessed, if any, the Department must compare the number of claims where violations occurred with the number of claims reviewed. An accurate number cannot be determined using the current ratio, which compares the number of claims where non-complying acts are found to exist with the total number of claims handled by the insurer during the relevant time period. As Department examiners cannot review all claims handled by an insurer, there would be no way of knowing whether non-complying acts or violations were contained within those files not reviewed.

Comment No.: **26**
Section: **2695.12(a)(7)**
Commentator: Ruben Cruz, SAFECO Insurance
Date of Comment: May 9, 2002
Type of Comment: Written

Summary of Comment: It is unclear whether this section as amended relates to claims reviewed by the Department during a market conduct exam or a claim reviewed by the Department as a result of a consumer complaint. The latter would not be a true reflection of the "average" claim, as a majority of claims are handled without consumer complaint.

Response to Comment: The Commissioner has considered this comment and rejects it. This section pertains to both market conduct exams and consumer complaints. However, the ratio between number of claims reviewed and number of violations found will be viewed differently depending on whether the violations are found during the course of a market conduct exam (where the examiner typically reviews hundreds of claims files) or through individual consumer complaints.

Comment No.: **37**
Section: **2695.12(a)(7)**
Commentator: Bennett L. Katz, Farmers Insurance Group
Date of Comment: May 8, 2002
Type of Comment: Written

Summary of Comment: To make the section unambiguous, a comparison should be made between the number of a company's justified versus unjustified complaints.

Response to Comment: The Commissioner has considered the comment and rejects it. The ratio suggested does not work as the regulations apply to both individual consumer complaints and market conduct exams. The concept of justified versus unjustified complaints applies only to individual consumer complaints (see Title 10, California Code of Regulations, section 2694.)

Comment No.: **35**
Section: **2695.12(a)(7)**
Commentator: Kent Keller, Barger and Wolen, on behalf of 21st Century Insurance Company
Date of Comment: May 7 and 8, 2002
Type of Comment: Written and Oral

Summary of Comment: Under the proposed amendment, if one noncompliant act is found in a claim file, the file would be deemed noncompliant when, in fact, the file could be 99% compliant based on the number of acts represented in the file. Due to the sheer number of potential noncompliant acts in a single file, one insignificant error could cause the file to be in "violation" and would artificially inflate the insurer's error ratio.

Response to Comment: The Commissioner has considered this comment and rejects it. The Commissioner has considered this comment and rejects it. During an examination of an insurer's claim file, examiners make note of how many violations are found within a particular file. Whether the insurer had multiple violations in only a few files or single violations in several files is not relevant in considering this particular factor. However, other factors in this subsection also help the commissioner determine appropriate penalties. These factors include complexity of the claim, previous violations, and degree of harm caused by the violation. Claims with multiple violations may be more complex (a mitigating factor) or cause greater harm to the claimant (an aggravating factor.) Subsection 2695.12(a)(7) must be read along with the other factors in subpart (a), not independently.

Comment No.: **29**
Section: **2695.12(a)(7)**
Commentator: Steve McManus, State Farm Insurance Companies
Date of Comment: May 9, 2002
Type of Comment: Written

Summary of Comment: State Farm objects to the proposed amendment because it is inconsistent with Insurance Code Section 790.03(h) which section establishes a business practice standard.

Response to Comment: The Commissioner has considered this comment and rejects it. As the Preamble to these regulations reflects, it is an unfair claims practice for an insurer to commit knowingly on a single occasion any of the sixteen claims settlement practices set forth in Insurance Code Section 790.03(h).

Comments RE: Section 2695.12(a)(8)

Comment No.: **4**
Section: **2695.12(a)(8)**
Commentator: John Metz
Date of Comment: April 24 and May 8, 2002
Type of Comment: Written and Oral

Summary of Comment: The Commentator specifies the remedial measures to be taken by the insurer that will affect the amount of penalty to be assessed.

Response to Comment: This comment is rejected as it falls outside the scope of the proposed rulemaking.

Comments RE: Section 2695.12(a)(11)

Comment No.: **4**
Section: **2695.12(a)(11)**
Commentator: John Metz
Date of Comment: April 24 and May 8, 2002
Type of Comment: Written and Oral

Summary of Comment: The Commentator proposes language that evidence of the insurer's attempt to comply with the regulations must be verified through information contained in the claim file.

Response to Comment: This comment is rejected as it falls outside the scope of the proposed rulemaking. It is unreasonable to require that all information be verified under penalty of perjury. As the current regulations reflect, is to consider the totality of the circumstances in determining whether the insurer made a good faith effort to comply with the regulations.

Comments RE: Section 2695.12(a)(13)

Comment No.: **4**
Section: **2695.12(a)(13)**
Commentator: John Metz
Date of Comment: April 24 and May 8, 2002
Type of Comment: Written and Oral

Summary of Comment: The Commentator suggests adding the word "adequate before the words "remedial measures."

Response to Comment: This comment is rejected as it falls outside the scope of the proposed rulemaking. By definition, remedial measures must be adequate or they would not be remedial.

Comments RE: Section 2695.12(c)

Comment No.: **18**
Section: **2695.12(c)**
Commentator: Samuel Sorich, National Association of Independent Insurers
Date of Comment: May 8, 2002
Type of Comment: Oral and Written

Summary of Comment: The current section is consistent with Insurance Code Insurance Code Section 790.03(h) because the latter's prohibition against unfair claims practices must be "knowingly" committed or performed with a frequency to indicate a general business practice. Reasonable mistakes are not knowing violations. The Initial Statement of Reasons explains that the section is being repealed because its intent is encompassed in the language of Section 2695.12(a)(11) (which specifies that the Commissioner shall consider evidence that, under the totality of circumstances, the licensee made a good faith attempt to comply with the regulations). Under the proposed amendment, Section 2695.12(a)(11) will only be considered as a factor in determining an appropriate penalty and does nothing to prevent a reasonable mistake from serving as the basis for a violation of the regulations.

Response to Comment: The Commissioner accepts the commentator's suggestions in part and rejects them in part. If an act is not in compliance with the regulations, it is necessarily in violation of the regulations. The term "knowingly committed" does not change that. The insurer necessarily has knowledge that it is committing an act even if it does not know that it is committing a violation of the Insurance Code and/or regulations. A reasonable mistake would not be a willful violation but it is still a violation.

However, an insurer's reasonable mistakes or opinions should be taken into consideration in determining whether or how much of a penalty should be assessed. In order to make that concept clear, proposed Section 2695.12(a) is further amended as follows: **(14) the licensee's reasonable mistakes or opinions as to valuation of property, losses or damages.**

Comment No.: **11**
Section: **2695.12(c)**
Commentator: Jeffrey J. Fuller, Association of California Insurance Companies
Date of Comment: May 7 and 8, 2002
Type of Comment: Written and Oral

Summary of Comment: An insurer's "reasonable mistakes" should be considered in determining penalties to be assessed.

Response to Comment: The Commissioner has considered this comment and agrees. An insurer's reasonable mistakes or opinions should be taken into consideration in determining whether or how much of a penalty should be assessed. In order to make that concept clear, proposed Section 2695.12 is further amended as follows: **(14) the licensee's reasonable mistakes or opinions as to valuation of property, losses or damages.**

Comments RE: Section 2695.14

Comment No.: **13**
Section: **2695.14**
Commentator: G. Diane Colborn, Personal Insurance Federation of California
Date of Comment: May 7 and 8, 2002
Type of Comment: Written and Oral

Summary of Comment: The changes to the regulations should take effect 120 days after being filed with the Secretary of State (and not 75 days as proposed.) The initial regulations allowed 120 days for implementation and this is a more reasonable time frame for companies to comply with such major changes in claims practices.

Response to Comment: The commissioner has considered the comment, accepts it in part and rejects it in part. The commissioner concedes that 75 days may be too short a time in which to implement the changes. However, 120 days is unnecessary as insurers already have the vast majority of claims handling requirements in place. The section shall now provide:

> These regulations shall take effect ~~one hundred and twenty (120) calendar days after they are filed with the Secretary of State. Any further amendments to the regulations shall take effect seventy-five (75)~~ **ninety (90) calendar** days after they are filed with the Secretary of State.

Comment No.: **29**
Section: **2695.14**
Commentator: Steve McManus, State Farm Insurance Companies
Date of Comment: May 9, 2002
Type of Comment: Written

Summary of Comment: With thousands of agents and claims employees to train regarding the comprehensive changes to these regulations, the effective date of the regulations should remain 120 days from the date they are filed with the Secretary of State.

Response to Comment: The Commissioner has considered the comment, accepts it in part and rejects it in part. The commissioner concedes that 75 days may be too short a time in which to implement the changes. However, 120 days is unnecessary as insurers already have the vast majority of claims handling requirements in place. Section 2695.14(a)n shall now provide:

> These regulations shall take effect ~~one hundred and twenty (120) calendar days after they are filed with the Secretary of State. Any further amendments to the~~

~~regulations shall take effect~~ ~~seventy-five (75)~~ **ninety (90) calendar** days after they are filed with the Secretary of State.

Comment No.: **4**
Section: **2695.14**
Commentator: John Metz
Date of Comment: April 24 and May 8, 2002
Type of Comment: Written and Oral

Summary of Comment: This section should specify that the regulations have applied to claims since the effective date of the underlying statutes, Insurance Code Sections 790.03(h) and 790.06.

Response to Comment: The Commissioner has considered this comment and rejects it. Laws pertaining to insurer claims handling practices were set down in writing in the statutes referred to by the Commentator. Although the laws giving rise to the regulations have applied to insurer claims handling since the effective date of Insurance Code Sections 790.03(h) and 790.06, the actual regulations did not become effective until January 14 1993 (and were subsequently amended and became operative on May 10, 1997.)